

FILED JUL 31 1944

318

1003

Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Desloge Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town Neier  
(If outside city or town limits, write "RURAL") NR  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

366505

3. (a) PRINT Anna C. Heitzler  
FULL NAME

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife August Heitzler 6. (c) Age of husband or wife if alive 54 years  
7. Birth date of deceased Nov. 16, 1892  
(Month) (Day) (Year)

8. AGE: Years 51 Months 8 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation athome

11. Industry or business \_\_\_\_\_

12. Name Jaacob Kolasch

13. Birthplace "Austria 4"  
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Zang

15. Birthplace Austria 4  
(City, town, or county) (State or foreign country)

16. (a) Informant August Heitzler

(b) Address Neier, Missouri

17. (a) Burial (b) Date thereof 7/26/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

17. (c) Place of burial or cremation Neier, Missouri

18. (a) Signature of funeral director Weick Boos.

(b) Address 2201 S. Grand Bl.

19. (a) J. F. Bredet (b) \_\_\_\_\_  
(Date received and local registrar's name) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23  
year 1944 hour 5 minute 25 P.M.

21. I hereby certify that I attended the deceased from July 22nd 1944 to July 23 1944  
that I last saw her alive on July 22 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis  
Brachial Thrombosis (Pt)  
Auricular Fibrillation  
Due to Acute Heart Failure  
Duration 4 days  
3 days  
23 days

Due to Hypertensive-cardio-vascular disease

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature A. J. Kotkin (M. D. or other) \_\_\_\_\_

Address 462 N. Taylor, St. Louis, Mo. Date signed 7/24/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER, FATHER

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Registered Apprentice No.....  
working under my personal supervision.

Signed

*W. A. Stewart*

Licensed Embalmer No. **3722**

P.O. Address **412 Duchouquette St.**

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**