

Registration District No. **317**

Primary Registration District No. **6076**

Registrar's No. **1987**

1. PLACE OF DEATH:
(a) County **St. Louis County**
(b) City or town **Ballwin, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Pine Crest Homes
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Mo. 13 da**
(Specify whether
In this community **4** years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **96**
(c) City or town **Ballwin**
(If outside city or town limits, write "RURAL")
(d) Street No. **1**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Anna Kalert**
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **21** year **1944** hour **6** minute **45 P.** M.

4. Sex **F** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive **28** years

21. I hereby certify that I attended the deceased from **July 20** 19 **44** to **Sept 21** 19 **44**
that I last saw her alive on **Sept 23** 19 **44**
and that death occurred on the date and hour stated above.

7. Birth date of deceased **Jan. 28 1857**
(Month) (Day) (Year)

Immediate cause of death
Cerebral Hemorrhage

8. AGE:	Years	Months	Days	If less than one day
	87	7	27	hr. min.

Due to
Due to

9. Birthplace **Missouri St Louis 0**
(City, town, or county) (State or foreign country)

Other conditions **Chr-Intestinal Infection**
(Include pregnancy within 3 months of death)

10. Usual occupation **Retired**

Major findings:
Of operations
Of autopsy **1312**

MOTHER FATHER
11. Industry or business
12. Name **Johnbert Oker**
13. Birthplace **St. Louis Co Mo 0**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **St. Louis Co Mo 0**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Elizabeth McComel**
(b) Address **2827 Brookwood Blvd**

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?

17. (a) **Burial** (b) Date thereof **9-27-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Peter's Cem**

(Specify type of place)
(a) While at work? (b) Means of injury

18. (a) Signature of funeral director **Louis H. Boyer Inc**
(b) Address **Turkwood Mo**

19. (a) **SEP 29 1944** **E. J. McLauran M.D.**
(Date registered) (Registrar's signature) (City)

Address **Manchester Mo** Date signed **9/25/44**

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

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..... *Samuel Szymon*

Licensed Embalmer No. *4343*

P. O. Address *7415 Daphin Pl. Mo.
Maplewood, Mo.*

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.