

No. 2  
1-5-43  
5-17-39  
I X36871

#32909  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 379  
Registrar's No. 64

FILED JAN 10 1945

Registration District No. 10 Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County St. Louis, Missouri.  
(b) City or town St. Louis, Missouri.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 1mo-12 days  
(Specify whether  
In this community 0  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2019 S. Broadway  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Anna Houser  
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 Dan Houser 6. (c) Age of husband or wife if alive 35 years  
7. Birth date of deceased October 6, 1911  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 2nd  
year 1945 hour 12:33 minute P. M.  
21. I hereby certify that I attended the deceased from 11/19/44  
to 1/2/45, 19\_\_\_\_, to 1/2/45, 19\_\_\_\_;  
that I last saw her alive on 1/2/45, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of cervix Duration 6 mo. ?  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions HSA  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
33 2 26 hr. min.  
9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name Ernst Lippert  
13. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Fannie Potts  
15. Birthplace England  
(City, town, or county) (State or foreign country)  
16. (a) Informant Dan Houser  
(b) Address 2019 S. Broadway  
17. (a) Burial (b) Date thereof Jan. 5, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Matthews Cemetery  
18. (a) Signature of funeral director Weick Bros.  
(b) Address 2201 S. Grand Bl.  
19. (a) JAN 4 1945 J. F. Brudeck  
(Date received local registrar) (Registrar's signature)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy Carcinoma of cervix  
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 Robert E. Hallet M.D.  
1515 Lafayette (City or town) (State)  
Date signed 1/2/45

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

MOTHER FATHER

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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.....

*Wang G. 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.**

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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)

3. (a) PRINT FULL NAME

Anna Hauser

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased Oct 6  
(Month) (Day) (Year)

8. AGE: Years 23 Months 2 Days 2 If less than one day..... min.

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

10. Usual occupation Housewife

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) JAN 19 1945 (b) J. F. Brueck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 1945 year 1945 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from..... 19.....  
that I last saw him..... alive on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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..... (M. D. or other)

Address..... Date signed.....

SUPPLEMENTARY

MOTHER FATHER

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