S. No. 2
M—8-43
v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11010

FILED APR 23 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3280

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: Barnes Hospital, O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days (Specify whether years, months or days)
In this community 57 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 749 Leland
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Anna Block
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 widow
6. (b) Name of husband or wife Nathan Block
6. (c) Age of husband or wife if alive years
7. Birth date of deceased unknown (Month) (Day) (Year)
8. AGE: Years about 82 Months — Days If less than one day hr. min.
9. Birthplace Memel (City, town, or county) East Prussia (State or foreign country)
10. Usual occupation at home
11. Industry or business

FATHER
12. Name Michael Gieber
13. Birthplace East Prussia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace East Prussia (City, town, or county) (State or foreign country)

16. (a) Informant A. Block
(b) Address 749 Leland U. City
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 4/13/45 (Month) (Day) (Year)
(c) Place: burial or cremation Beth Ham. Hag.
18. (a) Signature of funeral director Berger Memorial
(b) Address 4715 McPherson ave.
19. (a) APR 13 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11th year 1945 hour 4 minute 50 P.M.
21. I hereby certify that I attended the deceased from April 13, 1945 to April 11th, 1945 that I last saw h. alive on April 11, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumonia, lobar	1 wk.
Cerebral arteriosclerosis	
Due to Arteriosclerotic heart disease	
Senile psychosis	
Due to Malnutrition	

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Not done

Of autopsy Not done

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

23. Signature Louis A. Gottschalk (M. D. or other)
Address Barnes Hospital, Date signed 4/11/45

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 1597

P. O. Address.....

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.