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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18844

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5181

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: FIRM DESLOGE HOSP
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 3854 LOUGHBOROUGH CT
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ANTON HOLLERBACK

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife ANNA

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased NOV (Month) 20 (Day) 1872 (Year)

8. AGE: Years 72 Months 6 Days 21 If less than one day hr. min.

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

10. Usual occupation RETIRE 15 YR

11. Industry or business PLASTING CONTRACTOR

FATHER 12. Name JOHN HOLLERBACK

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

MOTHER 14. Maiden name KATHERINE BURKART

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

16. (a) Informant ANTHONY HOLLERBACK

(b) Address 3854 LOUGHBOROUGH

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-14-45 (Month) (Day) (Year)

(c) Place: burial or cremation NEW PETER PAUL

18. (a) Signature of funeral director KRIEGSHAUSER

(b) Address 4228 SO KINGSHIGHWAY

19. (a) JUN 12 1945 (Date received local registrar) J. F. Breffeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 11 year 1945 hour 2.30 AM minute M.

21. I hereby certify that I attended the deceased from June 7, 1945, to June 10, 1945, that I last saw him alive on 6-10, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Infarction	5 days
Due to: arteriosclerosis	
Due to:	
Other conditions: Cardiac Failure (Include pregnancy within 3 months of death)	3 weeks
Kidney failure	

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) none

(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 A J Steiner (M. D. or other) MD

Address 634 N Grand Ave Date signed 6/11/45

(Licensed Embalmer's Statement on Reverse Side)

Dr Stevens
Mo Bldg

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 Edwin D McDermo

Licensed Embalmer No. 3024

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.