

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9771**

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:  
Christian Hospital 0  
(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 St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4033 Palm Street,  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Anna Rose

3. (b) If veteran, name war No. 3. (c) Social Security No. None

4. Sex Female / 5. Color or race White 6. (a) Single, widowed, married, divorced Widow 7  
6. (b) Name of husband or wife Rose, Dec'd 5/22/34 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased. Nov. 11, 1875  
(Month) (Day) (Year)

8. AGE: Years 69 Months 11 Days 26 If less than one day  
hr. \_\_\_\_\_ min.

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

10. Usual occupation. At home

11. Industry or business Housewife

12. Name. John Santrock

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

14. Maiden name \_\_\_\_\_  
15. Birthplace. Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant. Ruth Rose,

(b) Address. 4033 Palm Street

17. (a) Burial (b) Date thereof. 11/10/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove

18. (a) Signature of funeral director. Robert J. Ambruster

(b) Address. Clayton Rd. at Concordia Lane

19. (a) NOV 10 1945 J. F. Brueck  
(Date received) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 7  
year 1945 hour 5 minute 40 P. M.

21. I hereby certify that I attended the deceased from 11-7 1945 to Nov. 7, 1945  
that I last saw her alive on Nov. 7, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death. Cerebral Haemorrhage Duration 10 da  
Due to hypertension 8  
Due to Nephritic interstitial 5

Other conditions. \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations. \_\_\_\_\_  
Of autopsy. No 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?

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

23. Signature. L. A. Mellis (M. D. or other)  
Address. Lindell Trust Bldg. Date signed. 11/8/45

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

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17  
9

NOV 17 1945  
NOV 17 1945

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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.....

Licensed Embalmer No..... 1994

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.**