

No. 2
M-5-43
7. 5-17-39
X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3261**
Registrar's No. **13**

FILED JAN 17 1947

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 St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri Baptist Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

In this community 40 years.

3. (a) PRINT FULL NAME Anna M. Wegman

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frank C. Wegman 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased March 27, 1881
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
65	9	4	hr. min.

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

10. Usual occupation Housewife.

11. Industry or business

12. Name George Santel

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

14. Maiden name Mary Stuckenberg

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

16. (a) Informant Frank C. Wegman

(b) Address 2129 Adelaide Ave.

17. (a) Burial (b) Date thereof 1/4/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 2117 E. Grand Ave.

19. (a) JAN 3 1947 (b) J. F. Bredbeck
(Date received local registrar) (Registrar's signature)

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. 2129 Adelaide Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 1 year 1947 hour 11 minute A. M.

21. I hereby certify that I attended the deceased from January 1-8 1946 to June 1 1947, 19____; that I last saw her alive on June 1 1947, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 2 days

Due to hypertension

Due to _____

Other conditions [Signature]
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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 C. G. [Signature] (M. D. or Ph.D.) _____

Address 1927 [Signature] Date signed 1-2-47

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 *Frank A. Johnson*

Licensed Embalmer No. *3041*

P. O. Address *2117 E. Grand*

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.