

No. 2  
-1/47  
-17-39

UNITED STATES DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **22075**  
Registrar's No. **5847**

Registration District No. **1947**  
**318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution:  
City Infirmary Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3/28/46/6/14/47  
(Specify whether)

In this community.....  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mad

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

(d) Street No. 5800 Arsenal St.  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No) 13  
If yes, name country.....

3. (a) PRINT FULL NAME Anna Bong

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

4. Sex Female 5. Color or White

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

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

7. Birth date of deceased July 14 1884  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>62</u>	<u>11</u>	<u>0</u>	.....hr. ....min.

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

10. Usual occupation House wife

11. Industry or business.....

12. Name Andrew Haag

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

14. Maiden name Rose ? Nagel

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

16. (a) Informant City Infirmary Hospital  
(b) Address 5800 Arsenal St.

17. (a) Burial (b) Date thereof 6/16/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Gebken-Benz Mortuary  
(b) Address 2842 Meramec St.

19. (a) 15 1947 (b) J. F. Bredack  
(Date received local registrar) (Registrar's signature)

MOTHER-FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 14 day 14  
year 1947 hour 3 minute 35 a.m.

21. I hereby certify that I attended the deceased from 3  
28....., 1946 on 6/14/....., 1947  
that I last saw him..... alive on....., 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Cerebral vascular accident 83A  
Due to  
Primary  
Pneumonia 10 days  
uremia 107 days

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

Major findings:  
Of operations.....

Of autopsy.....

PHYSICIAN  
Underline the cause of 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?..... Means of injury.....

23. Signature M. P. Shoney D. or other) P  
Address 5600 Arsenal signed 6-14-47

*Embalmer's separate cert. filed*

JUN 15

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.....

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.