. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 4 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 29592

Registrar's No. 8055

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Babtist 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: Missouri (b) County:
(c) City or town: St. Louis (If outside city or town limits, write "RURAL")
(d) Street No.: 5417a Union Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Anna D. Tochtrop
3. (b) If veteran, name war: —
3. (c) Social Security No.:

4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Divorced
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: September (Month) 17 (Day) 1872 (Year)

8. AGE: Years 74 Months 11 Days 6 If less than one day hr. min.

9. Birthplace: Missouri (City, town, or county) (State or foreign country)
10. Usual occupation: At Home
11. Industry or business:
MOTHER FATHER
12. Name: Anton Tochtrop
13. Birthplace: Germany (City, town, or county) (State or foreign country)
14. Maiden name: Theresa ?
15. Birthplace: Germany (City, town, or county) (State or foreign country)
16. (a) Informant: Leo Tochtrop
(b) Address: 6302 Oleatha Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/26/47 (Month) (Day) (Year)
(c) Place: burial or cremation: St. Peters Cem St. Charles, Mo.
18. (a) Signature of funeral director: Stroot-Carroll
(b) Address: 4600 Natural Bridge
19. (a) AUG 25 1947 (Date received local registrar) (b) J. F. Barlach (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 23 year 1947 hour 2 minute 15 A M.

21. I hereby certify that I attended the deceased from 8/21, 1947, to 8/23, 1947; that I last saw her alive on 8/22, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Post-op Heat Prostration	18 hrs
arteriosclerotic C-V-D	5 years
disease	
Due to:	
earlier heat prostration	
Due to: about 8/12/47	
Other conditions: Thrombosis R femoral artery	4 days

(Include pregnancy within 3 months of death)

Major findings of operation: R mid thigh amputation 8/22/47 — gangrene to knee
Of autopsy: none

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?
(e) Means of injury:

23. Signature: Willard Barlach Jr. (M.D. or other) MD
Address: 607 N Grand Date signed: 8/25/47

Jefferson City Printing Co.

(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. 4366

P. O. Address St Louis MO

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.