

No. 2
-1/47
5-17-39

36539

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 20 1947
Registration District No. _____

Primary Registration District No. 3069

Registrar's No. 2174

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
St. Mary's Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Ows

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

(d) Street No. 5625 Winona Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME ANNA MILLECKER

3. (b) If veteran, name war None 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 July 26 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	69	2	18 hr. min.

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

10. Usual occupation..... Housework

11. Industry or business.....

MOTHER FATHER { 12. Name Henry Mayer

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

14. Maiden name Unknown

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

16. (a) Informant Rose Millecker

(b) Address 5625 Winona Ave.

17. (a) Burial (b) Date thereof 10-17-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Resurrection Cem.

18. (a) Signature of funeral director Kriegshauser Und. Co.

(b) Address 4228 So. Kingshighway Bl.

19. (a) 10-16-47 (b) Carla J. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 14
year 1947 hour 12:30 minute A. M.

21. I hereby certify that I attended the deceased from Jun 1, 1947 to Oct 14, 1947
that I last saw her alive on Oct 13, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Cerebral hemorrhage 1hr.
Cerebral thromboses 5mos.
Arterio sclerosis

Due to.....

Other conditions..... 430
(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?..... (c) Means of injury.....

23. Signature Carusella (M. D. or other) 10

Address 3720 Washington Date signed 10/14/47

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

APR 12 1948

Register of 115
Washington

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..... *Richard W. Stovesand*

*Licensed Embalmer No..... *4007*

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.