

300
0-47
7-39
3908

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 28 1948
Registration District No. _____

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24276**
Registrar's No. **5572**

Primary Registration District No. **1002**

318

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital-Max Q. Starklof
(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 Mo. (b) County _____
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 4136 TAFT AVE
Memorial (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ANNIE FLAIG (Also FLAIG)
3. (b) If veteran, name war ✓
3. (c) Social Security No. NONE

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 18th
year 1948 hour 5 minute 40 P M.
21. I hereby certify that I attended the deceased from 6/10/48
_____, 19____, to June 18th, 1948
that I last saw her alive on June 18th, 1948
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife THEODORE E. FLAIG
6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased JANUARY 10, 1863
(Month) (Day) (Year)

Immediate cause of death
Arteriosclerotic heart disease
Duration _____

8. AGE: Years 85 Months 5 Days 8
If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions Psychosis with cerebral arteriosclerosis
(Include pregnancy within 3 months of death)

9. Birthplace JEFFERSON COUNTY, Mo. (1)
(City, town, or county) (State or foreign country)
10. Usual occupation NONE

Major findings: Cerebral arteriosclerosis
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business AT HOME
12. Name JOSEPH KOENIG
13. Birthplace UNKNOWN
(City, town or county) (State or foreign country)
14. Maiden name MARY ENS
15. Birthplace ST. LOUIS, Mo. (1)
(City, town, or county) (State or foreign country)

16. (a) Informant THEODORE E. FLAIG
(b) Address 4136 TAFT AVE

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?

17. (a) BURIAL (b) Date thereof JUNE 22, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation S. S. PETER PAUL CEM.
18. (a) Signature of funeral director Wm. Robert G. Co.
(b) Address 1905 S. GRAND BLVD
19. (a) JUL 2 1948 (b) J. F. Braddock
(Date received local health dept.) (Registrar's signature)

While at work Accidentally Means of injury (1) road
1515 Lafayette 6/19/48
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

MOTHER, FATHER

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

J. Allen Reynolds

Licensed Embalmer No. *4056*

P. O. Address *St. Louis*

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.