

FILED AUG 12 1948  
318THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No.

24313

Registrar's No.

6936

Registration District No.

Primary Registration District No.

## 1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **6400 Fyler Ave.** /  
(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)

3. (a) PRINT FULL NAME **ANNA KATHERINE GLAMANN**

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

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

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

7. Birth date of deceased..... **March 15 1870**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**78 4 21** hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business.....

12. Name..... **Unknown**

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

14. Maiden name.....

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

16. (a) Informant **Mrs. Russell Sanders**

(b) Address **6400 Fyler Ave.**

17. (a) **Burial** (b) Date thereof **Aug. 9 1948**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peters Cem.**

18. (a) Signature of funeral director **C. Hoffmeister Colonial Mortuary**

(b) Address **6464 Chippewa St.**

19. (a) **AUG 7 - 1948** (b) **J.F. Beedeck**  
(Date received local registrar) (Registrar's signature)

## 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. **6400 Fyler**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **6th** year **1948** hour **5** minute **50** P.M.

21. I hereby certify that I attended the deceased from **May 8** 1948 to **Aug 6** 1948  
that I last saw him alive on **Aug 5** 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
**Pericardial Anemia**  
**Myocarditis**  
**Arteriosclerosis**  
Due to.....

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

Major findings:  
Of operations.....

Of autopsy.....

## PHYSICIAN

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)  
(c) Means of injury.....  
23. Signature **C. Hoffmeister** (M. D. or other) **MD**  
Address **3228 Franklin Ave** Date signed **8-6-48**

Dr. C. V. Wilcox

**STATEMENT 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

*Harry J. Schumacher*

Licensed Embalmer No. *2679*

P. O. Address *7814 E. Broadway*

**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**