

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27559**
Registrar's No. **7256**

FILED AUG 28 1948 **318**
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**

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

(c) Name of hospital or institution:
3527 Wisconsin 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 BUDDE**

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 **Widowed**

6. (b) Name of husband or wife **Charles H. Budde**

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

7. Birth date of deceased **January 3 1876**
(Month) (Day) (Year)

8. AGE: Years **72** Months **7** Days **14**
If less than one day hr. _____ min. _____

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Unknown Albers**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Carl L. Budde**

(b) Address **4946 Aldine Place**

17. (a) **Burial** (b) Date thereof **8-20-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St Johns Cemetery**

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

(b) Address **4228 So. Kingshighway Blvd.**

19. (a) **AUG 18 1948** (b) **J. F. Bradeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **One**

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

(d) Street No. **24** **3527 Wisconsin Ave.**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **17th**
year **1948** hour **7:30** minute _____ P.M.

21. I hereby certify that I attended the deceased from **December 1947** to **Aug 17 1948**
that I last saw her alive on **Aug 17** and that death occurred on the date and hour stated above.

Immediate cause of death **Congenital heart failure** Duration **6 hrs**

Due to **Arteriosclerosis HD.**

Due to **930**

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. W. Hoffman** (M. D. or other) _____
Address **406 S. 2nd St.** Date signed **8/18/48**

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.....

.....
working under my personal supervision.

....., Registered Apprentice No.....

Signed.....

Richard W. Stovessand

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.