

FILED JAN 19 1949

STANDARD CERTIFICATE OF DEATH

State File No. 2779

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 165

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. CITY (If outside corporate limits, write RURAL and give township) St Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 14 3919 Hereford	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3919 Hereford			

3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) c. (Last) Heitland		4. DATE OF DEATH (Month) 1/6/49 (Day) (Year)	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 22, 1871
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	11. BIRTHPLACE (State or foreign country) St Louis, Mo.
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME William Teuerborn		13b. MOTHER'S MAIDEN NAME Louise Wortmann		14. NAME OF HUSBAND OR WIFE Frank	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Frank R Heitland	
				ADDRESS 4995 Parker	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Ch. myocardi, chr nephritis, Hypertension, Disturb</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Aug 19 1944, to Jan 6 1949, that I last saw the deceased alive on Jan 5 1949, and that death occurred at 8:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE <i>R. Berg MD</i>		(Degree or title)		23b. ADDRESS 3203 S. Grand St Louis Mo		23c. DATE SIGNED 1-7-49	
24a. BURIAL CREMATION, REMOVAL (Specify) burial		24b. DATE 1/10/49		24c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery		24d. LOCATION (City, town, or county) (State) St Louis Mo	

DATE REC'D BY LOCAL JAN 7 1949		REGISTRAR'S SIGNATURE <i>J B Lacater</i>		25. FUNERAL DIRECTOR'S SIGNATURE J L Ziegenhein & Sons		ADDRESS 7027 Gravois	
-----------------------------------	--	---	--	---	--	-------------------------	--

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

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 _____

Student Embalmer No. _____

Working under my personal supervision.

Student
Student Embalmer

Signed Frank Owens

Licensed Embalmer No. 2245

P. O. Address 7027 Gravois

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.