

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6775
1933

FILED MAR 11 1949

318

1003

State File No.

Registrar's No.

| | | | | | | | |
|--|---|--|--|---|------------------------------------|--|----------------------------------|
| BIRTH NO. | | REG. DIST. NO. | | PRIMARY REG. DIST. NO. | | Registrar's No. | |
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, write RURAL and give town(ship) OR TOWN St. Louis | | c. LENGTH OF STAY (in this place) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | 19 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hosp. | | | | d. STREET ADDRESS (If rural, give location) 4251 Clay Avenue | | | |
| 3. NAME OF DECEASED (Type or Print) Theresa Vitt. a. (First) b. (Middle) c. (Last) | | | 4. DATE OF DEATH (Month) (Day) (Year) Feb. 28 1949 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH Feb 3, 1888 | | 9. AGE (In years last birthday) 61 | IF UNDER 1 YEAR Months 0 Days 25 | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) St. Louis, Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13a. FATHER'S NAME August Schaum | | 13b. MOTHER'S MAIDEN NAME Anna Peter | | 14. NAME OF HUSBAND OR WIFE Anton Vitt (Dec) | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Frank Vitt. 4251 Clay Avenue | | | | | |
| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Obstruction of bronchi due to dense adhesions</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>1/22</u> DUE TO (c) <u>3705</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION Feb 21-49 Dense adhesions | | | | | 20. AUTOPSY? YES <input checked="" 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) | 21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | | | | | |
| 22. I hereby certify that I attended the deceased from Feb 21, 1949, to Feb 27, 1949, that I last saw the deceased alive on 2-27, 1949, and that death occurred at 2:42 p.m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) Dr. A. Bronschwig M.D. | | | 23b. ADDRESS 3121 N Grand | | | 23c. DATE SIGNED 2-28-49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Mar 2, 1949 | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 24d. LOCATION (City, town, or county) St. Louis | | (State) | |
| DATE REC'D BY LOCAL REGISTRY MAR 1 1949 | REGISTRAR'S SIGNATURE J. D. Foster | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 4746 West Florissant Av | | | | |

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

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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.

Signed W. Wilkins

Signed
Student Embalmer

Licensed Embalmer No. 3575

P. O. Address St Louis Mo

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.