

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

FILED OCT 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35675

State File No. ....

318

1003

Registrar's No. 8685

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. _____		Registrar's No. 8685					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____									
b. CITY (If outside corporate limits, write RURAL and give townshp) OR TOWN <u>St. Louis</u>			c. LENGTH OF STAY (In this place) _____			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>			17				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2641 Gravois Ave.</u>				d. STREET ADDRESS (If rural, give location) <u>23 2641 Gravois Ave.</u>									
3. NAME OF DECEASED (Type or Print) <u>Anna</u>		a. (First)		b. (Middle)		c. (Last) <u>Waller</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 6, 1949</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Sept. 6, 1878</u>		9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>0</u>		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13a. FATHER'S NAME <u>John Waller</u>				13b. MOTHER'S MAIDEN NAME <u>Anna Henrichs</u>				14. NAME OF HUSBAND OR WIFE _____					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____				16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Elizabeth Waller 2641 Gravois Ave.</u>							
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized Carcinomatosis</u>  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.  1948								INTERVAL BETWEEN ONSET AND 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) <u>35</u>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>1949</u>									
22. I hereby certify that I attended the deceased from <u>July 19 1947</u> to <u>OCT 6, 1949</u> , that I last saw the deceased alive on <u>OCT 6, 1949</u> , and that death occurred at <u>10:30A</u> m., from the causes and on the date stated above.													
23a. SIGNATURE <u>John W. Dacke M.D.</u> (Degree or title)				23b. ADDRESS <u>4254<sup>2</sup> Arsenal</u>				23c. DATE SIGNED <u>10-6-49</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 10, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, MO.</u>							
DATE REC'D BY LOCAL REG. <u>OCT 9 1949</u>		REGISTRAR'S SIGNATURE <u>J. R. Lasater</u>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John H. Gebken Sons Und, Co. 2630 Gravois Ave.</u>							

**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 Robert F. Gebken

Signed.....  
Student Embalmer

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.