

FILED MAR 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10925
State File No. 2090

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

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) OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 2019	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3900 Bates St		d. STREET ADDRESS (If rural, give location) 1-3900 Bates St 6	
3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Ortgies c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Mar - 2 1950	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH July 13 1868 87
9. AGE (In years less birthday) 6 19 IF ORDER IN HRS. Hours Min.		11. BIRTHPLACE (State or foreign country) Germany 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Aug. Falkenhain	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Hans	
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. Unknown	
17. INFORMANT'S SIGNATURE OR NAME Eleanor Henneke		ADDRESS 3900 Bates St	
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) Rt hemiplegia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive arteriosclerosis DUE TO (c) Diabetes mellitus II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
INTERVAL BETWEEN ONSET AND DEATH 2 days yes yes		19a. DATE OF OPERATION	
19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 2601		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?	
22. I hereby certify that I attended the deceased from 1945 to March 2, 1950 that I last saw the deceased alive on 3-1 , 1950, and that death occurred at 10:30 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Dee Beard (Degree or title)		23b. ADDRESS 1703 S Grand	
23c. DATE SIGNED 3-2-50		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE Mar 6 1950		24c. NAME OF CEMETERY OR CREMATORY Mo Cremators	
24d. LOCATION (City, town, or county) (State) St Louis Mo		DATE REC'D BY LOCAL REG. MAR 4 1950	
REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE Fendler Undertaking Co	
ADDRESS 7420 Mich Ave			

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

Dr Boyd MoPa

real

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 *VE Morris*

Licensed Embalmer No. *3360*

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.