

FILED MAY 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15085

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3903**

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) OR TOWN ST. LOUIS MO		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2169	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 3103^{1/2} GRAVOIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3103^{1/2} GRAVOIS			

3. NAME OF DECEASED (Type or Print)	a. (First) ANNA	b. (Middle) -	c. (Last) WACHTENDORF	4. DATE OF DEATH (Month) (Day) (Year) APRIL 27 1950
-------------------------------------	------------------------	----------------------	------------------------------	--

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW 2	8. DATE OF BIRTH Nov. 23 1876	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR 6 Months	IF UNDER 24 HRS. 4 Hours
----------------------	-------------------------------	---	--------------------------------------	---	---------------------------------	---------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTENDANT	10b. KIND OF BUSINESS OR INDUSTRY RECREATION CENTER	11. BIRTHPLACE (State or foreign country) ST. LOUIS MO	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	--	---	---

13a. FATHER'S NAME CHARLES SUCHER	13b. MOTHER'S MAIDEN NAME MARY AECHTLE	14. NAME OF HUSBAND OR WIFE GEORGE WACHTENDORF (DECEASED)
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME REGINA TSCHANI	ADDRESS 3103 GRAVOIS
---	-------------------------------	---	-----------------------------

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatous - abdominal		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
	ANTECEDENT CAUSES Morbidity 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 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) 1991
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 1991
--	--	--

22. I hereby certify that I attended the deceased from **April 1948**, to **27 April 1950**, that I last saw the deceased alive on **27 Apr. 1950**, and that death occurred at **11:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Robert A. Nye, M.D. (Degree or title)	23b. ADDRESS 3201 Arsenal St.	23c. DATE SIGNED 28 Apr. 50
---	--------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAY 1 1950	24c. NAME OF CEMETERY OR CREMATORY S.S. PETER + PAUL	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
---	-----------------------------	---	---

DATE REC'D BY LOCAL REG. APR 29 1950	REGISTRAR'S SIGNATURE J.B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis	ADDRESS 2906 Gravois
---	---	--	-----------------------------

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

10-11-24 3:00 pm
Date

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: *Loj Budde*

Licensed Embalmer No. *3989*

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.