

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 9 1951

1003 State File No. 10746
2694

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		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 <u>MISSOURI</u> b. COUNTY _____			
b. CITY OR TOWN <u>ST. LOUIS Mo</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>ST. LOUIS</u>		2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. ANTHONY'S HOSPITAL</u>				11. STREET ADDRESS (If rural, give location) <u>3329 VIRGINIA</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u>		b. (Middle) <u>-</u>		c. (Last) <u>WACHSMANN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MAR. 21 1951</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>DEC. 21, 1898</u>	
9. AGE (In years last birthday) <u>52</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOX MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DRUG PKG. INC.</u>		11. BIRTHPLACE (State or foreign country) <u>ST. LOUIS Mo U</u>	
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <u>ERNST WACHSMANN</u>		13b. MOTHER'S MAIDEN NAME <u>MARIA GRUBENWALD</u>		14. NAME OF HUSBAND OR WIFE _____	
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 ADDRESS <u>MARIA WACHSMANN 3329 VIRGINIA</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) _____		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Subacute Dehydration</u>				INTERVAL BETWEEN ONSET AND DEATH _____	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Black; Anorexia Hypertrophic Curvature of liver; uremia</u>				DUE TO (b) <u>being prepared for operation removal of uterus job at</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>St. Anthony's Hosp an</u>		DUE TO (c) <u>Mar 21 1951, about 10:25 am</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>ood</u>				21. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21b. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis Mo</u>		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above.			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		23a. SIGNATURE (Degree or title) <u>Patrick C Taylor Coroner</u>			
21f. HOW DID INJURY OCCUR _____		23b. ADDRESS <u>1300 Clark</u>		23c. DATE SIGNED <u>3.22.51</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>MAR 26 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>S. S. PETER & PAUL</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>	
DATE REC'D BY LOCAL REG. <u>MAR 22 1951</u>		REGISTRAR'S SIGNATURE <u>Jr B Lassater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutie 7906 Gravois</u>			

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

