

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2470

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis Co.	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN Normandy		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Normandy 4151	
c. LENGTH OF STAY (in this place) 3 yrs.		d. STREET ADDRESS (If rural, give location) 6825 Natural Bridge Rd.,	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Mother Of Good Council Home			

3. NAME OF DECEASED (Type or Print) a. (First) ANNA	b. (Middle) J.	c. (Last) ERNST	4. DATE OF DEATH (Month) (Day) (Year) June 20, 1951.
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 9	8. DATE OF BIRTH May 19, 1869	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo. 0	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Micheal Kierman	13b. MOTHER'S MAIDEN NAME Mary Bradley	14. NAME OF HUSBAND OR WIFE Geo. F. Ernst Dec.
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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 Rev. J.E. Ernst, 17 Joy Ave.,
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 mos  6 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) General Arteriosclerosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) Chronic Nephritis - Uremia DUE TO (c) Senility		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Right Hemiplegia			6 yrs

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE none	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) none
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21d. TIME OF INJURY none	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? none
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22. I hereby certify that I attended the deceased from June 1949, to June 20, 1951, that I last saw the deceased alive on June 19, 1951, and that death occurred at 0:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. Stachle M.D.	23b. ADDRESS 7124 Natural Bridge	23c. DATE SIGNED 6-20-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 0	24b. DATE June 25, 1951	24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.,	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. 6-21-51	REGISTRAR'S SIGNATURE Robert A. Jones M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jos. W. Clark 1125 Hodiamont Ave.,
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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

*Alfred J. Boedelser*

Licensed Embalmer No. *2443*

P. O. Address *11257 Hudson*

**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.