

FILED JUL 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25000**
6295

BIRTH NO.		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No.
1. PLACE OF DEATH a. COUNTY 0		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 township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2189	
d. FULL NAME OF HOSPITAL OR INSTITUTION Marian Hospital		d. STREET ADDRESS (If rural, give location) 3212 Vista Ave. 0		
3. NAME OF DECEASED (Type or Print) a. (First) Anna		b. (Middle) C.	c. (Last) Merk	4. DATE OF DEATH (Month) (Day) (Year) July 13, 1951
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH April 19, 1871	9. AGE (In years last birthday) 80 If under 1 year: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Owensville, Mo. 0
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Philip Merk		
13b. MOTHER'S MAIDEN NAME Charlotte Beckman		14. NAME OF HUSBAND OR WIFE James Shelton		
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 Charlotte Lemons, Poplar Bluff, Mo.
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis DUE TO (c) Hypertension II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H43 X
22. I hereby certify that I attended the deceased from 7/4 19 51 , to 7/13 19 51 , that I last saw the deceased alive on 7/13 19 51 , and that death occurred at 1:05p m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) Otto C. Hanson MD		23b. ADDRESS 3012 Lafayette Ave		23c. DATE SIGNED 7/14/51
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-13-51		24c. NAME OF CEMETERY OR CREMATORY Owensville, Mo.
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.		
DATE REC'D BY LOCAL REG. JUL 14 1951		REGISTRAR'S SIGNATURE [Signature]		

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 *Robert M Murray* _____

Licensed Embalmer No. *3749* _____

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.