

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17632**
Registrar's No. **19**

FILED JUN 13 1952

BIRTH NO. _____ REG. DIST. NO. **305** PRIMARY REG. DIST. NO. **6047**

1. PLACE OF DEATH a. COUNTY St Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY St Charles	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN O'Fallon Mo Rural		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN O'Fallon Mo Rural	
c. LENGTH OF STAY (in this place) 7 yr		d. STREET ADDRESS (If rural, give location) 9111 South East	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Barbara c. (Last) Hemmer			4. DATE OF DEATH (Month) (Day) (Year) June 4 1952		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Mar. 17 1877		9. AGE (In years last birthday) 75		10. UNDER 1 YEAR: Months 2 Days 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) St Paul Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Joseph Feldman		13b. MOTHER'S MAIDEN NAME Elizabeth Hozz		14. NAME OF HUSBAND OR WIFE Frank Hemmer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME Mrs Leona Heppermann O'Fallon Mo	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		DUPLICATE			
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 **5/30**, 19**52**, to **6/4**, 19**52**, that I last saw the deceased alive on **6/4**, 19**52**, and that death occurred at **5⁰⁰** a.m., from the causes and on the date stated above.

23a. SIGNATURE George R. Seabek MD		23b. ADDRESS O'Fallon Mo		23c. DATE SIGNED 6-9-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE June 7-52		24c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Dardenne	
24d. LOCATION (City, town, or county) (State) 1170					

DATE REC'D BY LOCAL REG. June 10 1952		REGISTRAR'S SIGNATURE Mark J. Puff		25. FUNERAL DIRECTOR'S SIGNATURE ST. E. PITMAN	
				ADDRESS FUNERAL HOME WENTZVILLE 1170	

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

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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.

Signed

Annietta M. Pittman

Signed _____

Student Embalmer

Licensed Embalmer No. 3055

P. O. Address Westville, N.C.

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.