

FILED JUL 5 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23054

1001
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 590 Registrar's No. 1701

1. PLACE OF DEATH <u>AT HOME</u> a. COUNTY <u>ST. LOUIS COUNTY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>OHIO</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>GLENDALE MO.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>COLUMBUS</u> <u>8340</u>	
c. LENGTH OF STAY (in this place) <u>1 WEEK</u>		d. STREET ADDRESS (If rural, give location) <u>292 SOUTH JAMES Rd.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>48 CHEYENNE COURT, GLENDALE</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u> b. (Middle) <u>MIDDENDORF</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 21 1952</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>AUG. 18 1889</u>
9. AGE (In years last birthday) <u>62</u>		10. UNDER 1 YEAR Months <u>10</u> Days <u>3</u>	11. UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME HOUSEWIFE</u>	11. BIRTHPLACE (State or foreign country) <u>COLUMBUS OHIO</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>AUGUST SCHWENK</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
14. NAME OF HUSBAND OR WIFE <u>JOSEPH MIDDENDORF</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>W. C. SCHOFIELD 48 CHEYENNE CT.</u>			
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) <u>Coronary Occlusion</u> ANTECEDENT CAUSES Morbid 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 <u>4201</u>	
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)		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 <u>6-21, 1952</u> , to _____, 19____, that I last saw the deceased alive on <u>6-21, 1952</u> , and that death occurred at <u>10 P. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>L. R. Allen</u> (Degree or title) <u>D.O.</u>		23b. ADDRESS <u>614 O Line</u>	
23c. DATE SIGNED <u>6-21-52</u>			
24a. PREMIA (REMOVAL) _____		24b. DATE <u>JUNE 25 1952</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>GREENLAWN CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>COLUMBUS OHIO</u>	
DATE REC'D BY LOCAL REG. <u>6-22-52</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Donke MD</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>G. H. Booklage</u>		ADDRESS <u>6536 Clayton Rd.</u>	

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 _____

Licensed Embalmer No. 4865

P. O. Address _____

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.