

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 11 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1099**

1. PLACE OF DEATH a. COUNTY		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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2247	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2909a Lemp Ave		d. STREET ADDRESS (If rural, give location) 24 2909a Lemp Ave	
3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) c. (Last) Balzer		4. DATE OF DEATH (Month) (Day) (Year) Jan 29 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Feb 25 1867
9. AGE (In years last birthday) 85		10. MONTHS 0	11. DAYS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Adam Balzer	
13b. MOTHER'S MAIDEN NAME Catherine Dreis		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) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Olin Wuerz
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) Influenza DUE TO (c) Cerebral Thrombosis 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 checked="" type="checkbox"/> NO <input type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 2 days	
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? 480X	
22. I hereby certify that I attended the deceased from Jan 27, 1953 , to Jan 29, 1953 , that I last saw the deceased alive on Jan 28, 1953 , and that death occurred at 5:35 A.M. from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Dr. Rumer M.D.		23b. ADDRESS 204 S. Jefferson	
23c. DATE Jan 29 1953		23d. DATE Jan 29 1953	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Feb 2 1953	24c. NAME OF CEMETERY OR CREMATORY St Peter & Paul	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.
DATE REC'D BY LOCAL REG. JAN 30 1953	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Heick Bros Funeral Home	
ADDRESS 2201 S. Grand Ave		(Licensed Embalmer's Statement on Reverse Side)	

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

Dr H.M. Kinner

3016 S. Jefferson Ave

12 to 2

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: *Dr H.M. Kinner*

Licensed Embalmer No. *4366*

P. O. Address *Harvard*

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.