

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11636
2401

FILED MAR 24 1953

1003 State File No.
318 REG. DIST. NO. PRIMARY REG. DIST. NO. Registrar's No.

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. LENGTH OF STAY (in this place) c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2089	
d. FULL NAME OF HOSPITAL OR INSTITUTION Park Lane Hospital		d. STREET ADDRESS (If rural, give location) 720 Bittner St.,	
3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Haase c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) March 1st, 1953
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH April 29th, 1904
9. AGE (In years or under 1 year last birthday) 48		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Jacob Schilling		13b. MOTHER'S MAIDEN NAME Mary Gassel	14. NAME OF HUSBAND OR WIFE Frank F. Haase
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. 492-10-2068B	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bernard Haase, 4874 Calvin
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) Pulmonary Infarction myocardial ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial Infarction 2 tabs. DUE TO (c) Bacteremia strept. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Tonsillitis - strept	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Pus Streptococcus Blood Culture	
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) ST. LOUIS, MO	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 051X		22. I hereby certify that I attended the deceased from Sept 1, 1952 , to March 1, 1953 , that I last saw the deceased alive on March 1, 1953 , and that death occurred at 9:15 P.M. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Nancy Rosenberg M.D.		23b. ADDRESS 1467 Union Bl.	
23c. DATE SIGNED Mar 2 1953		24a. BURIAL, CREMATION, REMOVAL (Specify) burial	
24b. DATE 3/4/53		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Diedrich F. Home 8319 Hallsferry	
DATE REC'D BY LOCAL REG. MAR 3 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

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

John J. Davis

Licensed Embalmer No. 4108

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.