

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2852

FILED MAR 31 1953

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>2852</b>		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Lemay</b>		<b>4890</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Anthony Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>1425 Wachtel ave.</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Anna</b> b. (Middle) <b>-----</b> c. (Last) <b>Voigt</b>			4. DATE OF DEATH <b>March 14, 1953</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Aug. 18, 1860</b>		
9. AGE (In years last birthday) <b>92</b>		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 1 HR. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>-----</b>	
13a. FATHER'S NAME <b>Conrad Bohne</b>			13b. MOTHER'S MAIDEN NAME <b>Caroline Rau</b>			14. NAME OF HUSBAND OR WIFE <b>August</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Alma Waninger 278 Pardella ave. Lemay</b>			
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) <b>Apoplexy</b>  ANTECEDENT CAUSES <b>Arteriosclerosis</b> 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.  INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>						
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) (Min.) _____		
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>334X</b>						
22. I hereby certify that I attended the deceased from <b>March 7, 1953</b> , to <b>March 19, 1953</b> , that I last saw the deceased alive on <b>March 17, 1953</b> , and that death occurred at <b>1.45 pm.</b> , from the causes and on the date stated above.								
23a. SIGNATURE <b>A. H. Peters M.D.</b> (Degree or title)				23b. ADDRESS <b>704 Lemay</b>		23c. DATE SIGNED <b>3/16/53</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>March 18, 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>2000 Lemay Ferry Road, Lemay</b>		
DATE REC'D BY LOCAL REG. <b>MAR 16 1953</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>C. Hoffmeister U.&amp;L.Co.</b>		ADDRESS <b>7814 S. Broadway</b>		

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

*Leina C. Hoffmeister*

Licensed Embalmer No. 3871

P. O. Address 7814 S Broadway

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.