

FILED JUL 31 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 26595  
Registrar's No. 6016

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3880 Marine Av		c. CITY OR TOWN St Louis 2249 d. STREET ADDRESS (If rural, give location) 24 3880 Marine Av 0	
3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Marie c. (Last) Kraus			4. DATE OF DEATH (Month) (Day) (Year) June 15 1953
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov 15 1876
9. AGE (In years less birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo.
13a. FATHER'S NAME Joseph Pollack		13b. MOTHER'S MAIDEN NAME Anna Korando	14. NAME OF HUSBAND OR WIFE William (Deceased)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Pollack 3880 Marine Av
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>Cerebral Apoplexy</u> ANTECEDENT CAUSES <u>Hypertension</u> 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	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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 334x	
22. I hereby certify that I attended the deceased from <u>June 10, 1953</u> , to <u>June 19, 1953</u> , that I last saw the deceased alive on <u>June 4, 1953</u> , and that death occurred at <u>10:47</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Dr. Sam B. Bissmer, M.D.</u>		23b. ADDRESS <u>3014 S. Jefferson Ave</u>	23c. DATE SIGNED <u>June 16/53</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6/17/53	24c. NAME OF CEMETERY OR CREMATORY New St Marcus Cem	24d. LOCATION (City, town, or county) (State) St Louis Missouri
DATE REC'D BY LOCAL REG. JUN 16 1953	REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Moydell Funeral Home 1926 Allen Av</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 me

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Reinhold K. Lohrm

Licensed Embalmer No. 3395

P. O. Address \_\_\_\_\_

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.