

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26753

State File No. 6683  
Registrar's No. 6683

FILED JUL 31 1953

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>6683</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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS Mo</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>ST. LOUIS</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST ANTHONY Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>3406 ARSENAL</b>				269	
3. NAME OF DECEASED (Type or Print) a. (First) <b>CLARA</b>			b. (Middle) _____			c. (Last) <b>PAAR</b>			
4. DATE OF DEATH (Month) (Day) (Year) <b>JULY 5 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>MAY 24 1892</b>			9. AGE (In years last birthday) <b>61</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WIDOW</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>AT Home</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>NEBRASKA</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>WILLIAM GREUNWALD</b>			13b. MOTHER'S MAIDEN NAME <b>Louise SAUERSWIEG</b>			14. NAME OF HUSBAND OR WIFE <b>MARKUS PAAR (DEC'D)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME & ADDRESS <b>MARGARET MANN 3408 - ARSENAL</b>			_____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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 _____						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) <b>420,0</b>					
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? _____					
22. I hereby certify that I attended the deceased from <b>July 5, 1952</b> , to <b>July 5, 1953</b> , that I last saw the deceased alive on <b>July 5, 1953</b> and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>John H. Bent MD</b>			23b. ADDRESS <b>2840 S California</b>			23c. DATE SIGNED _____			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>JULY 8 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>SUNSET BURIAL</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Mo</b>			
DATE REC'D BY LOCAL REG. <b>JUL 6 1953</b>		REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>			25. FUNERAL DIRECTOR'S SIGNATURE & ADDRESS <b>Thomas Lutis 2906 Beairon</b>				

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

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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.....  
Signature of Student Embalmer

Signed *Leo J. Cudde*.....

Licensed Embalmer No. *3989*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.