

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30392**

FILED AUG 31 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2768**

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY 2077 | |
| b. CITY OR TOWN St. Louis, Missouri | | c. CITY OR TOWN St. Louis | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) | | e. STREET ADDRESS (If rural, give location) 7 5959 Harney | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1 | | | |

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|--|------------|-------------|----------------------------|-----------------------------------|----------------------|
| 3. NAME OF DECEASED (Type or Print) Anne | a. (First) | b. (Middle) | c. (Last) Sander | 4. DATE OF DEATH 8-6-53 | (Month) (Day) (Year) |
|--|------------|-------------|----------------------------|-----------------------------------|----------------------|

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|--------------------|------------------------------|--|------------------------------------|--|---------------------------|--------------------------|---------------------------|--------------------------|
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M | 8. DATE OF BIRTH 9-30-75 | 9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 24 HRS. Hours | IF UNDER 24 HRS. Min. |
|--------------------|------------------------------|--|------------------------------------|--|---------------------------|--------------------------|---------------------------|--------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) Scott County Mo 0 | 12. CITIZEN OF WHAT COUNTRY? Y |
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| 13a. FATHER'S NAME Casper Eiler | 13b. MOTHER'S MAIDEN NAME Willemenia | 14. NAME OF HUSBAND OR WIFE David |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) xxx | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME David Sander | ADDRESS 5959 Harney ave |
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| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 15 min. |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ACUTE PULMONARY EMBOLISM | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CONGESTIVE HEART FAILURE DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
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| 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) 420.0 |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 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 **8-2-53**, 19**53**, to **8-7**, 19**53**, that I last saw the deceased alive on **8-7**, 19**53**, and that death occurred at **4:00** P. m., from the causes and on the date stated above.

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| 23a. SIGNATURE <i>William A. ... M.D.</i> | (Degree or title) | 23b. ADDRESS 1515 Lafayette | 23c. DATE SIGNED |
|--|-------------------|---------------------------------------|------------------|

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|--|-----------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 8/10/53 | 24c. NAME OF CEMETERY OR CREMATORY Memorial Park | 24d. LOCATION (City, town, or county) (State) St Louis County |
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| DATE REC'D BY LOCAL REG. AUG 10 1953 | REGISTRAR'S SIGNATURE <i>[Signature]</i> | 25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> | ADDRESS Central Funeral Home 5511 Riverview |
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(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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Ben E Hoffman*
Licensed Embalmer No. *113*
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.