

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33321

FILED OCT 15 1953

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State File No. _____
Registrar's No. 8774

BIRTH NO. _____		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 <u>Missouri.</u> b. COUNTY _____			
b. CITY OR TOWN <u>Saint Louis, Missouri.</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>Saint Louis.</u>		2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>2 4620 Rosa Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Emil</u>		a. (First) _____		b. (Middle) <u>--</u>		c. (Last) <u>Haas</u>	
4. DATE OF DEATH <u>Sept. 8 1953.</u>		4. DATE (Month) (Day) (Year)		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>August 24, 1878</u>		9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Brewery Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Anheuser Busch.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>? Haas</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Anna Haas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>489-05-6915 A</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Anna Haas</u> ADDRESS <u>4620 Rosa Ave.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u> ANTECEDENT CAUSES <u>Myocarditis Chronic</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.				INTERVAL BETWEEN ONSET AND DEATH <u>8 Hrs.</u>	
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) <u>H20:1</u> (COUNTY) _____ (STATE) _____			
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 <u>Sept 1</u> , 19 <u>53</u> , to <u>Sept 8</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Sept 7</u> , 19 <u>53</u> , and that death occurred at <u>4:55 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>W. Wagnerbach M.D.</u> (Degree or title)				23b. ADDRESS <u>4717 Gravois Road</u>		23c. DATE SIGNED <u>9/8/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 11, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>		24d. LOCATION (City, town, or county) (State) <u>10180 Gravois Road Missouri</u>	
DATE REC'D BY LOCAL REG. <u>SEP 10 1953</u>		REGISTRAR'S SIGNATURE <u>Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mozegenken Bros.</u> ADDRESS <u>6409 Gravois A</u>			

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 _____

Law M. Simon

Licensed Embalmer No. _____

4343

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.