

FILED OCT 23 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **37269**BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9842**

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)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		
d. FULL NAME OF HOSPITAL OR INSTITUTION 6507 BRADLEY AVE			d. STREET ADDRESS (If rural, give location) 3 6507 BRADLEY		
3. NAME OF DECEASED (Type or Print)			a. (First) ANN		b. (Middle) M.
			c. (Last) HILL		4. DATE OF DEATH (Month) (Day) (Year) OCT, 12, 1953
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH 2/2/1882		9. AGE (In years last birthday) 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <input checked="" type="radio"/> ST. LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME PATRICK BURKE		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. #	17. INFORMANT'S SIGNATURE OR NAME JOHN E. CLIFFORD		
		ADDRESS 1981 ROSALIE AVE			
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) cardiac valvular disease 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. None			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 4214			
22. I hereby certify that I attended the deceased from 4-2 , 1952, to 10-12 , 1953, that I last saw the deceased alive on 10-12 , 1953, and that death occurred at 4 p m., from the causes and on the date stated above.					
23a. SIGNATURE J. P. Berman M.D.			23b. ADDRESS 1225 No. Grand		23c. DATE SIGNED 10-14-53
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 10/16/1953	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		24d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI	
DATE REC'D BY LOCAL REG. OCT 15 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE STROOT - CARROLL	
				ADDRESS 4600 NATURAL BRIDGE AVE	

(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
Student Embalmer

Signed M. W. R. Reiter

Licensed Embalmer No. 4865

P. O. Address St Louis, Mo

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.