

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37303**  
**8148**

FILED OCT 23 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

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 OR TOWN <b>St. Louis</b> )		c. LENGTH OF STAY (in this place) <b>10 yrs.</b>	c. CITY OR TOWN <b>St. Louis</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>5352 Arlington Ave.</b>		e. STREET ADDRESS (If rural, give location) <b>5352 Arlington Ave. 207 1/2</b>	
3. NAME OF DECEASED (Type or Print) <b>ANNA</b>		a. (First) <b>C.</b> b. (Middle) <b>JAHNSSEN</b> c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 21, 1953</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>June 1, 1870</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>83</b> IF UNDER 1 YEAR Months <b>2</b> Days <b>20</b> IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Germany</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>George Wallenstein</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>
14. NAME OF HUSBAND OR WIFE <b>Deceased</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>
17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Gertrude Schuermann</b>		ADDRESS <b>(above)</b>	
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) <b>Cerebral Embolism</b>  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. <b>Arteriosclerosis, Coronary</b>	
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) <b>332X</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>Aug 5</b> 19 <b>53</b> , to <b>Aug 21</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>Aug 20</b> , 19 <b>53</b> , and that death occurred at <b>4:10 A.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>John G. McInerney M.D.</b> (Degree or title)		23b. ADDRESS <b>5014 Thekla Av</b>	
23c. DATE SIGNED <b>8/22/53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>Aug 24 1953</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Rose Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Greenville, Ill.</b>	
DATE REC'D BY LOCAL REG. <b>AUG 22 1953</b>		REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>4746</b>		ADDRESS <b>Bromschwig and Son W Florissant</b>	

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 *John S. Penne*.....  
Licensed Embalmer No. *419*.....  
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.