

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

40455

State File No.

FILED NOV 27 1953

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **10884**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY 2019	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. LENGTH OF STAY (in this place) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. ANTHONY HOSPITAL		d. STREET ADDRESS (If rural, give location) 3859 BLOW STREET	
3. NAME OF DECEASED (Type or Print) a. (First) ANNA b. (Middle) MARIE c. (Last) FOX		4. DATE OF DEATH (Month) (Day) (Year) NOV. 14, 1953	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUGUST 14, 1878
9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MISSOURI 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME HERMAN WIESER		13b. MOTHER'S MAIDEN NAME ROSALIA GOETZ WIESER	14. NAME OF HUSBAND OR WIFE AUGUST P.
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. NONE	17. INFORMANT'S SIGNATURE OR NAME AUGUST P. FOX
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.		17. ADDRESS 3859 BLOW ST. ST. LOUIS, MO.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension			
DUE TO (c) Arteriosclerosis generalized			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None.			
19a. DATE OF OPERATION None	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 <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 334X	
22. I hereby certify that I attended the deceased from 12 Nov 53 , to 14 Nov 53 that I last saw the deceased alive on 14 Nov, 1953 , and that death occurred at 8:15 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE John L. Kellett MD		23b. ADDRESS 7602 S. Bevoys	23c. DATE SIGNED 11/16/53
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE NOV. 18, 1953	24c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEMETERY	24d. LOCATION (City, town, or county) (State) WATSON & MCKENZIE ROADS
DATE REC'D BY LOCAL REG. NOV 16 1953	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE G. HOFFMEISTER	
		ADDRESS 6264 CHIPPEWA ST. LOUIS, MO.	

(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 Harry J. Schumacher

Licensed Embalmer No. 2679

P. O. Address 7814 S. Broadway

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.