

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40894**
Registrar's No. **11314**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY 2037	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 10 days	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"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		e. STREET ADDRESS (If rural, give location) 5962 S. Cuba Court	

3. NAME OF DECEASED (Type or Print)	a. (First) Anna	b. (Middle)	c. (Last) Mohr	4. DATE OF DEATH (Month) (Day) (Year) 11 - 28 - 1953
--	------------------------	-------------	-----------------------	---

5. SEX Fem	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 10 - 2 - 1861	9. AGE (In years last birthday) 92	IF UNDER 1 YEAR Months	IF UNDER 1 MRS. Hours	Min.
10a. USUAL OCCUPATION (The kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) Germany		12. CITIZEN OF WHAT COUNTRY? 4		

13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE August Mohr
--------------------------------------	---	---

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 Mrs. Gertrude Stanley	ADDRESS 5962 S. Cuba Ct
---	-------------------------	---	-----------------------------------

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.	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary vessels and disease		INTERVAL BETWEEN ONSET AND DEATH 1951 + 1951 + Nov 16 / 53
	ANTECEDENT CAUSES *Mention conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis		
	OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. DUE TO (c) Age Fractured left hip		

19a. DATE OF OPERATION Operation	19b. MAJOR FINDINGS OF OPERATION No 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.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St Louis ? 442 PMo
--	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov 16 53 5p	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fell on floor at home
--	---	--

22. I hereby certify that I attended the deceased from **11-16**, 19**53**, to **11-28**, 19**53**, that I last saw the deceased alive on **11-28**, 19**53**, and that death occurred at **4:20 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Reinhardt	(Degree or title)	23b. ADDRESS 1117 N. Grand	23c. DATE SIGNED 11-30-53
------------------------------------	-------------------	--------------------------------------	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12/1/53	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cem.	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.
---	-----------------------------	--	--

DATE REC'D BY LOCAL REG. NOV 30 1953	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harrel	ADDRESS 1905 Union Blvd.
--	---	--	------------------------------------

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0

Dr. Emmet Kane
1117 N. Grand

Sat. 2-4
Mon. 2-4

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..... *Albert R. Thompson*

Licensed Embalmer No. *493*

P. O. Address *H. J. ...*

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.