

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41379

FILED NOV 24 1953

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10779**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: De Paul Hospital		e. STREET ADDRESS (If rural, give location) 5222a N. 20th St.	
3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) B. c. (Last) Wiedmann		4. DATE OF DEATH (Month) (Day) (Year) Nov. 11 1953	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Nov. 16 1892
9. AGE (In years last birthday) 60		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 Mo.
13a. FATHER'S NAME Louis Jakle		13b. MOTHER'S MAIDEN NAME Mary Brady	14. NAME OF HUSBAND OR WIFE Fred Wiedmann
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 ADDRESS Fred Wiedmann 5222a N. 20th St.
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) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 5 yrs 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.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200	
22. I hereby certify that I attended the deceased from 8-22-52 to 11-11-53 , that I last saw the deceased alive on Nov 11, 1953 , and that death occurred at 1:10 A. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Chas. J. Smith, M.D.		23b. ADDRESS 6000 W. Florissant	23c. DATE SIGNED 11-13-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-13-53	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis MO.
DATE REC'D BY LOCAL REG. NOV 13 1953	REGISTRAR'S SIGNATURE Carl Smith MO	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Buchholz Koeller 5967 W. Florissant	

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 *W. H. Buckholz*.....

Licensed Embalmer No. *4551*.....

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.