

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41665

State File No. ....

FILED NOV 25 1953

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>500</u>		Registrar's No. <u>2828</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Remay</u>		c. LENGTH OF STAY (in this place) <u>2 YEARS</u>		c. CITY OR TOWN <u>Gardenville</u>		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 <u>Mt St Rose Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>4667 Heidelberg Av</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ann</u> b. (Middle) <u>M</u> c. (Last) <u>Hermann</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 31, 1953</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec 28 1914</u>	
9. AGE (In years last birthday) <u>38</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 48 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Sylvester Buban</u>			13b. MOTHER'S MAIDEN NAME <u>Katherine Klaric</u>		14. NAME OF HUSBAND OR WIFE <u>John Hermann</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John Hermann 4667 Heidelberg Av</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u>  ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <u>Theroplasty (2nd stage)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>          <u>8 days</u>	
19a. DATE OF OPERATION <u>23 Oct 53</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (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 <u>28 Dec, 1952</u> , to <u>23 Oct, 1953</u> , that I last saw the deceased alive on <u>31 Oct, 1953</u> , and that death occurred at <u>10:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>John F. McLean M.D.</u>				23b. ADDRESS <u>9101 S. Broadway</u>		23c. DATE SIGNED <u>2 Nov 53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>11/4/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St Louis Mo.</u>	
DATE REC'D BY LOCAL REG. <u>11/3/53</u>		REGISTRAR'S SIGNATURE <u>Heber B. Amke M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Moydell Funeral Home 1926 Allen Av</u>			

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

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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 *Reinhold K. Lehmann*

Licensed Embalmer No. *3395*

P. O. Address .....

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.