

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **9877**  
**2538**  
Registrar's No. \_\_\_\_\_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 <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <b>St. Louis</b>		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 <b>Christian Hospital</b>			e. STREET ADDRESS (If rural, give location) <b>24 3417 Texas Avenue</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Anna</b> b. (Middle) <b>S.</b> c. (Last) <b>Baum</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>March 18, 1954</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 17, 1886</b>	9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Warren County, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>----- Faes</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Charles Baum</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Roy E. Baum 5045 So. 37th St.</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>Coronary Thrombosis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Arterio-Sclerosis</b>  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.				INTERVAL BETWEEN ONSET AND DEATH <b>1 month</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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <b>4201</b>				
22. I hereby certify that I attended the deceased from <b>Mar 14, 1954</b> , to <b>Mar 18, 1954</b> , that I last saw the deceased alive on <b>Mar 18, 1954</b> and that death occurred at <b>6 PM</b> , from the causes and on the date stated above.						
23a. SIGNATURE <b>L. B. Resnikoff M.D.</b>			23b. ADDRESS <b>3612 S. Jefferson</b>		23c. DATE SIGNED <b>Mar 19 1954</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Mar. 22, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>		
DATE REC'D BY LOCAL REG. <b>MAR 19 1954</b>		REGISTRAR'S SIGNATURE <b>G. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wacker - Alderle - 3634 Gravois Ave.</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.....  
*Frank J. Hyland*

Licensed Embalmer No.....  
*26*

P. O. Address.....  
*W. Long*

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.