

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10050**
2639

FILED MAR 31 1954

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4018 NEOSH0		d. STREET ADDRESS (If rural, give location) 24 3172 NEBRASKA	

3. NAME OF DECEASED (Type or Print)	a. (First) ANNA	b. (Middle) -	c. (Last) GEISEL	4. DATE OF DEATH (Month) (Day) (Year) MAR. 23 1954
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH JAN. 6, 1874	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIDOW	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State of foreign country) GERMANY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME EDWARD KLIMPEL	13b. MOTHER'S MAIDEN NAME UNKNO WN	14. NAME OF HUSBAND OR WIFE WILLIAM GEISEL (Dec'd)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME MRR. T. RICHTERS	ADDRESS 3172 NEBRASKA
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis 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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 334 X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **June 1953**, to **Mar. 23, 1954**, that I last saw the deceased alive on **Mar 22, 1954**, and that death occurred at **4:20 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph E. Caney MD	23b. ADDRESS 906 Olive	23c. DATE SIGNED 3-23-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE MAR. 26 1954	24c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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DATE REC'D BY LOCAL REG. MAR 23 1954	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis	ADDRESS 2906 Prairie
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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

Leo J. Budde

Licensed Embalmer No.

3989

P. O. Address

St. Louis, Mo.

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 this body is not embalmed, fact should be so stated above.