

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10178**  
**2619**

BIRTH NO. **FILED MAR 31 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2619**

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b> |  | c. CITY OR TOWN <b>St. Louis, Mo.</b>   | 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: <b>gietner Home</b>                                       |  | e. STREET ADDRESS (If rural, give location) <b>2925 University st.</b>                |  |

|                                     |                        |                             |                       |   |
|-------------------------------------|------------------------|-----------------------------|-----------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>Anna</b> | b. (Middle) <b>Margaret</b> | c. (Last) <b>Kern</b> | 4. DATE OF DEATH (Month) (Day) (Year) <b>March 20th, 1954</b> |
|-------------------------------------|------------------------|-----------------------------|-----------------------|---|

|                      |                               |  |                                       |   |                             |                            |
|----------------------|-------------------------------|--|---------------------------------------|---|-----------------------------|----------------------------|
| 5. SEX <b>Female</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>W single</b> | 8. DATE OF BIRTH <b>May 6th, 1875</b> | 9. AGE (In years last birthday) <b>78</b> | IF UNDER 1 YEAR Months Days | IF UNDER 2 HRS. Hours Min. |
|----------------------|-------------------------------|--|---------------------------------------|---|-----------------------------|----------------------------|

|   |                                   |  |                              |
|---|-----------------------------------|--|------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) <b>Milstadt, Ill.</b> | 12. CITIZEN OF WHAT COUNTRY? |
|---|-----------------------------------|--|------------------------------|

|                                       |   |                             |
|---------------------------------------|---|-----------------------------|
| 13a. FATHER'S NAME <b>George Kern</b> | 13b. MOTHER'S MAIDEN NAME <b>Catherine Sparwasser</b> | 14. NAME OF HUSBAND OR WIFE |
|---------------------------------------|---|-----------------------------|

|  |                                     |  |                                    |
|--|-------------------------------------|--|------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b> | 16. SOCIAL SECURITY NO. <b>None</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>nella Weber</b> | ADDRESS <b>2925 University St.</b> |
|--|-------------------------------------|--|------------------------------------|

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|--|--|-------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a); (b); and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |       | INTERVAL BETWEEN ONSET AND DEATH<br><b>years ago</b> |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) <b>Arterio sclerosis</b>  |       |  |
|  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Cerebral hemorrhage</b> |       |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Hypertension Cerebro-malacia</b>  |  | years |  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 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) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <b>331X</b> |
|--|--|--|

22. I hereby certify that I attended the deceased from **May 15, 1952**, to **Mar 19, 1954**, that I last saw the deceased alive on **Mar 19, 1954**, and that death occurred at **9 P.** m., from the causes and on the date stated above.

|  |                             |  |                                 |
|--|-----------------------------|--|---------------------------------|
| 23a. SIGNATURE <b>P. J. Moskop, M.D.</b> | (Deed or title) <b>M.D.</b> | 23b. ADDRESS <b>355 + Victor St. St. Louis 4 Mo.</b> | 23c. DATE SIGNED <b>3/20/54</b> |
|--|-----------------------------|--|---------------------------------|

|   |                          |   |   |
|---|--------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> | 24b. DATE <b>3/23/54</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>New Picker Cemetery</b> | 24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b> |
|---|--------------------------|---|---|

|   |   |   |   |
|---|---|---|---|
| DATE REC'D BY LOCAL REG. <b>MAR 22 1954</b> | REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Kraeger</b> | ADDRESS <b>Funeral Home 3402 N. Kings-highway</b> |
|---|---|---|---|

(Licensed Embalmer's Statement on Reverse Side)

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

109

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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 *John J. Haine*.....

Licensed Embalmer No. *410*.....

P. O. Address *J. Haine*.....

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.