

FILED SEP 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29017

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>7545</u>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>St. Louis</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>DePaul Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>2109 10 3004 Lee Ave.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Anna</u> b. (Middle) <u>C.</u> c. (Last) <u>Kammann</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 13 1954</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>Mar. 18 1877,</u>		9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS. Days _____	IF UNDER 4 HRS. Hours _____	Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>John C. Schomburg</u>			13b. MOTHER'S MAIDEN NAME <u>Henrietta Probst</u>		14. NAME OF HUSBAND OR WIFE <u>August Kammann</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>August Kammann</u> ADDRESS <u>3004 Lee Ave.</u>					
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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary embolism, multiple</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hours.</u>		
	ANTECEDENT CAUSES Morbid conditions, (if any, giving rise to the above cause (a) stating the underlying cause last.) DUE TO (b) <u>Auricular fibrillation</u> DUE TO (c) <u>Heart failure</u>								
	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 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>465X</u>					
22. I hereby certify that I attended the deceased from <u>12 Aug, 1954</u> , to <u>13 Aug, 1954</u> , that I last saw the deceased alive on <u>12 Aug, 1954</u> , and that death occurred at <u>1:50 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Joseph A. Roy, M.D.</u>				23b. ADDRESS <u>7124 Natural Bridge</u>		23c. DATE SIGNED <u>16 Aug 54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/16/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>				
DATE REC'D BY LOCAL REG. <u>AUG 16 1954</u>		REGISTRAR'S SIGNATURE <u>A. Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Buchholz Mortuary 5967W. Florissant</u>					

(Licensed Embalmer's Statement on Reverse Side)

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 *Richard J. Bralich*

Licensed Embalmer No. *7557*

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.