

FILED DEC 13 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39536

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 544 Registrar's No. 2751

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirkwood		c. LENGTH OF STAY (in this place) 3 Years	c. CITY OR TOWN Sullivan
d. FULL NAME OF HOSPITAL OR INSTITUTION White Oaks Nursing Home		e. STREET ADDRESS (If rural, give location) 2223 Meredith Lane	

3. NAME OF DECEASED (Type or Print) a. (First) Anna	b. (Middle)	c. (Last) Lucksinger	4. DATE OF DEATH (Month) (Day) (Year) Nov 27 54
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec 12, 1868	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home.	11. BIRTHPLACE (City and State or Foreign Country) Beaufort Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.				

13a. FATHER'S NAME Arnold Brinkmeyer	13b. MOTHER'S MAIDEN NAME Caroline Horstmann	14. NAME OF HUSBAND OR WIFE Unk
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Nil.	17. INFORMANT'S SIGNATURE OR NAME Alice Fischer	ADDRESS Sullivan Mo
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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, asthma, 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) Cerebral artery embolism		few seconds
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis heart disease 10 yrs DUE TO (c) General arteriosclerosis 15 yrs		
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)
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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?
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22. I hereby certify that I attended the deceased from Oct 24, 1954 to Nov 27, 1954, that I last saw the deceased alive on 11-20, 1954, and that death occurred at 11:50 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M.D.	23b. ADDRESS 4500 W Pine St St Louis Mo	23c. DATE SIGNED 11-27-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 11-28-54	24c. NAME OF CEMETERY OR CREMATORY Leslie Mo	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. 11/29/54	REGISTRAR'S SIGNATURE Heather S. Lamborn	5. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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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.....
Signature of Student Embalmer

Signed *J. W. Dinkley*.....

Licensed Embalmer No. *3653*.....

P. O. Address *J. L. Lantz*.....

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.