

FILED APR 11 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9345

State File No.

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **2902**

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 town) St. Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION 4139 Shenandoah Ave.		STREET ADDRESS (If rural, give location) 3509 Chouteau Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Anna		b. (Middle)	c. (Last) Beer
4. DATE OF DEATH March 24 1955	5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 1873	9. AGE (In years last birthday) 81	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	10b. KIND OF BUSINESS OR INDUSTRY Unknown
11. BIRTHPLACE (City and State or Foreign Country) Unknown	12. CITIZEN OF WHAT COUNTRY? Unknown	13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Unknown	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Arthur Schenk - 6132 Marwinette
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio sclerotic Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Disease 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 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) (Min.)
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200		
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred on 5:37 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE [Signature]		23b. ADDRESS 1300 Clark	23c. DATE SIGNED 3/31/55
24a. BURIAL OR CREMATION REMOVAL (Specify) Burial	24b. DATE Mar. 31, 1955	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Ceme.	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
DATE REC'D BY LOCAL REG. MAR 31 1955	REGISTRAR'S SIGNATURE J. Earl Smith m.d.	25. FEDERAL DIRECTOR'S SIGNATURE ADDRESS Wacker-Helderte - 3634 Gravois Ave.	

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 *Robert C Wheeler*.....

Licensed Embalmer No. *212*

P. O. Address *Spain*

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.