

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14268

State File No.

FILED APR 27 1955

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>590</u>		Registrar's No. <u>893</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hillsdale</u>		c. LENGTH OF STAY (in this place) <u>4 1/2</u> years		c. CITY OR TOWN <u>Hillsdale</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>6800 St. Louis Avenue.</u>				STREET ADDRESS (If rural, give location) <u>6800 St. Louis Avenue</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u> b. (Middle) <u>STREICHER</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>April 16, 1955</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 30, 1873</u>		9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Wooliam, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Fritz Hengstenberg</u>			13b. MOTHER'S MAIDEN NAME <u>Henrietta Pollman</u>		14. NAME OF HUSBAND OR WIFE <u>Charles Streicher</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Fred Hengstenberg, 6800 St. Louis Avenue.</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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>none</u>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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"/>	
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) <u>4222</u>			
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? _____			
22. I hereby certify that I attended the deceased from <u>Sept 1st, 1954</u> to <u>4-16-1955</u> , that I last saw the deceased alive on <u>Apr 14, 1955</u> , and that death occurred at <u>8:55 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Clyde E. Kene M.D.</u>				23b. ADDRESS <u>706 Walton</u>		23c. DATE SIGNED <u>4-18-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>April 19, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>4/18/55</u>		REGISTRAR'S SIGNATURE <u>Robert K. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Shepard Funeral Home, 1167 Hamilton Ave</u>			

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

Elmo R. Sadwell

Licensed Embalmer No. *407*

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.