

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 15 1955

State File No. **34746**  
**8760**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (in this place) <b>3 1/2 weeks</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Firmin Desloge Hospital</b>		STREET ADDRESS (If rural, give location) <b>9 829 E. Prairie Avenue</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Anita</b>	b. (Middle) <b>V</b>	c. (Last) <b>Franke</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>October 5 1955</b>
-------------------------------------	-------------------------	----------------------	-------------------------	---

5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Separated</b>	8. DATE OF BIRTH <b>July 23, 1907</b>	9. AGE (In years last birthday) <b>48</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
----------------------	-------------------------------	---	---------------------------------------	---	------------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
--	--	---	--

13a. FATHER'S NAME <b>Edward E. Marquardt</b>	13b. MOTHER'S MAIDEN NAME <b>Matilda Schaperkoetter</b>	14. NAME OF HUSBAND OR WIFE <b>Unknown</b>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Arthur Trampe, RR #1, Marine, Illinois</b>	ADDRESS
---	--	--	---------

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <b>Asoxia; Congenital Heart</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Thrombosis of the left femoral artery. Cardiac arrest during operation for tetralogy</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death that not related to the disease or condition above. <b>Salute at Firmin Desloge Hospital, October 5th, 1955</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>about 10:55 am.</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
------------------------	---	--

21a. ACCIDENT (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Shop</b>	21c. (CITY, TOWN, OR TOWNSHIP), (COUNTY) (STATE) <b>St. Louis Mo</b>
---	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Oct 5 55 10:55 a.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>754.0</b>
--	--	---

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 **10:55 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Type or title) <b>Patrick C. Taylor Coroner</b>	23b. ADDRESS <b>1300 Clark</b>	23c. DATE SIGNED <b>10.7.55</b>
---	--------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>October 8, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
--	----------------------------------	--	---

DATE REC'D BY LOCAL REG. <b>OCT 7 1955</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Math Hermann &amp; Son, Inc., 2161 E. Fair Ave</b>	ADDRESS
--	--	--	---------

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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 *Welford G. Burns*.....

Licensed Embalmer No. *426*

P. O. Address *Shore*.....

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.