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Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 4 1957

STATE FILE NUMBER 2633

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 458

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Inside Limits: Yes ✓ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 2617 ECOFF — Length of stay in 1b: 32 YRS 2 3 4

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY
c. CITY OR TOWN: ST. LOUIS — Inside Limits: Yes ✓ No ☐
d. STREET ADDRESS (If outside, give location): 2617 ECOFF — Reside on Farm: Yes ☐ No ✓

3. NAME OF DECEASED (Type or print): First ANNA Middle — Last CRONBACH

4. DATE OF DEATH: Month 1 Day 15 Year 57

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4-9-1878

9. AGE (In years last birthday): 78

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / 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 country): AUSTRIA 4

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: CARL-MURWALD

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 495-22-3093A

17. INFORMANT Address: HERMAN-CRONBACH-2617 ECOFF

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 331x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑ /2

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 7 Jan 57 to 16 Jan 57 and last saw her/him alive on 14 Jan 57. Death occurred at 7:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): A. B. Calayan M.D.

22b. ADDRESS: 2705 Clifton

22c. DATE SIGNED: 15 Jan 57

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: 1-17-57

23c. NAME OF CEMETERY OR CREMATORY: OAK-HILL CEM.

23d. LOCATION (City, town, or county) (State): ST. LOUIS Co Mo

24. FUNERAL DIRECTOR ADDRESS: JAY-B-SMITH-Maplewood 17 Mo

25. DATE RECD. BY LOCAL REG.: JAN 16 '57

26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. M.J.B.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was en

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed H E Burgess

Licensed Embalmer No. 40

P. O. Address Maple

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.