

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18822

FILED MAY 27 1957

Registration District No. **318** Primary Registration District No. **1003** STATE FILE NUMBER **4541** 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, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>			Inside Limits #s <input type="checkbox"/> U <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>			Inside Limits #s <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>			Length of stay in lb <b>25</b>	d. STREET ADDRESS <b>3400 S. Grand Blvd.</b> (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>ANNA</b> First				Middle <b>MARY</b>		Last <b>HOLDENRIED</b>	
4. DATE OF DEATH <b>MAY 13, 1957</b>				5. SEX <b>Female</b> / 6. COLOR OR RACE <b>White</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 12, 1877</b>		9. AGE (In years last birthday) <b>80</b>	
IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> 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	
11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Theodore Kramer</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Kasellius</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Robert E. Holdenried 4210 a Juniata Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO (b) <del>Food poisoning</del> DUE TO (c) <b>Pneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Compensatory Heart failure</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b> <b>1 hr</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a. m.</b> Month, Day, Year p. m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>493x</b>	
20g. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20h. CITY, TOWN, OR LOCATION		20i. COUNTY		20j. STATE	
21. I attended the deceased from <b>4/25/57</b> to <b>5/13/57</b> and last saw her alive on <b>5/13/57</b> Death occurred at <b>4:15 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Thomas J. Roach M.D.</b> (Degree or title)				22b. ADDRESS <b>1515 LAFAYETTE AVE</b>		22c. DATE SIGNED <b>5/13/57.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>5/16/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>		
24. FUNERAL DIRECTOR <b>John H. Gebken Sons 2630 Gravois Ave.</b>				25. DATE RECD. BY LOCAL REG. <b>MAY 13 '57</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith Mrs</b>	

(Licensed Embalmer's Statement on Reverse Side)

Health, welfare, public service, 300 -56, 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

Practical.

Practical.

Practical.

Practical.

Practical.

Practical.

Practical.

Practical.

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 T. Gray* ..... Licensed Embalmer No. ....

P. O. Address 2630 Gravois

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.