

Health, Welfare, Public Service

300  
1-56

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

5591 FILED JUL 31 1957

25899  
STATE FILE NUMBER  
6787  
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

|   |                           |   |   |   |   |
|---|---------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                           |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Mo. b. COUNTY |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis  |                           | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN St. Louis   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                               |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION 01 6251 Delor  |                           | Length of stay in lb  | STREET ADDRESS 214 B 6251 Delor   |   | If outside, give location<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Mary Middle E Last Andert  |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>July 19, 1957   |   |   |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>July 22, 1894   |   | 9. AGE (In years last birthday)<br>82   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |                           | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br>St. Louis, Mo   |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |
| 13. FATHER'S NAME<br>John Egner   |                           |   | 14. MOTHER'S MAIDEN NAME<br>Caroline Egner  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)<br>No   |                           | 16. SOCIAL SECURITY NO.<br>None   | 17. INFORMANT<br>Paul J Andert 6251 Delor   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Generalized Metastases</i><br>DUE TO (b) <i>Cerebral Lesions</i><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>170 X |                           |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| 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<br>Hour Month, Day, Year<br>a. m.<br>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 COUNTY STATE |   |
| 21. I attended the deceased from April 56 and last saw her alive on June 18, 1957<br>Death occurred at 4:24 AM m on the date stated above; and to the best of my knowledge, from the causes stated.   |                           |   |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><i>Paul J Andert M.D.</i>   |                           |   | 22b. ADDRESS<br>1703 S. Grand   |   | 22c. DATE SIGNED<br>7-19-57   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal  |                           | 23b. DATE<br>7-22-57  | 23c. NAME OF CEMETERY OR CREMATORY<br>Resurrection Cemetery   |   | 23d. LOCATION (City, town, or county) (State)<br>St. Louis County Mo.                                   |
| 24. FUNERAL DIRECTOR<br>Kriegshauser 4228 So. Kingshighway  |                           |   | 25. DATE RECD. BY LOCAL REG.<br>JUL 22 57   |   | 26. REGISTRAR'S SIGNATURE<br><i>Carl Smith M.D.</i>   |

(Licensed Embalmer's Statement on Reverse Side)

m & B.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e  
by me, or by ..... Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *William B. Whit*.....

Licensed Embalmer No. *1-1*

P. O. Address *228 Edin*

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.