

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-007560  
STATE FILE NUMBER

FILED MAR 5 - 1958

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2222**

300  
-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Sangamon</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Geitner Home</b>		Length of stay in 1b <b>15 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>So. 5th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Mechler</b> Last <b>Mechler</b>			4. DATE OF DEATH <b>Feb. 23, 1958</b> Month Day Year		
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>Feb. 8, 1868</b>	9. AGE (In years last birthday) <b>90</b> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Carlinville, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Werse</b>		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE <b>Charles</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Dan Flynn, 4118 Minnesota, 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>Arteriosclerotic Heart Disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <b>None</b>				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <b>None.</b>					
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 <b>Feb. 10, 1958</b> to <b>Feb. 23, 1958</b> and last saw her alive on <b>Feb. 14, 1958</b> Death occurred at <b>11:30 AM.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Harbor A.C. Wiegand, M.D.</b>		22b. ADDRESS <b>3750 Washington</b>		22c. DATE SIGNED <b>2/24/58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2-23-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Carlinville, Illinois.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe 4700 Washington, Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 24 '58</b>	26. REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b> <i>m.j.B.</i>		

All diseases in Part I must be causally related.

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. Sadewell

Licensed Embalmer No. 4074

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.