

Health, Welfare, Public Service

FILED APR 28 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013435  
STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 99

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57

1. PLACE OF DEATH a. COUNTY <u>CALLAWAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FULTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Jefferson Barracks</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #1</u>		Length of stay in lb <u>19 yrs. 10 mos.</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u></u> Last <u>Foeller</u>			4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-1879</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>unk.</u>	13b. MOTHER'S MAIDEN NAME <u>unk.</u>	14. NAME OF HUSBAND OR WIFE <u>unk.</u>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk.</u>	16. SOCIAL SECURITY NO. <u>unk.</u>	17. INFORMANT <u>State Hospital #1; Fulton, Missouri</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease, congestive</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unkenna</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>noted</u>		
DUE TO (c) <u>4200</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 <u></u> Month <u></u> Day <u></u> Year <u></u> a.m. <u></u> p.m. <u></u>		

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> <u>State Hospital #1</u>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>State Hospital #1</u>	20f. CITY, TOWN, OR LOCATION <u>St Louis</u>	COUNTY <u>Mo</u>	STATE
21. attended the deceased from <u>April 14, 1958</u> to <u>April 23, 1958</u> and last saw her/him alive on <u>4-22-1958</u> Death occurred at <u>8:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>Thomas Stephen Morrison, M.D.</u>	22b. ADDRESS <u>State Hospital, Fulton</u>	22c. DATE SIGNED <u>4-23-1958</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4/26/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olive</u>	23d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>
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24. FUNERAL DIRECTOR <u>Maureen Funch</u>	ADDRESS <u>Home Fulton Mo</u>	25. DATE RECD. BY LOCAL REG. <u>April 26-1958</u>	26. REGISTRAR'S SIGNATURE <u>Maritta Lawrence</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

650, 9 4 113

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 *J. D. Ross* .....

Licensed Embalmer No. *2555* .....

P. O. Address *Quilley* .....

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.