Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-026798

STATE FILE NUMBER

FILED JUL 24 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6958

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes [X] No [ ]

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital — Length of stay in 1b 13 days

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 [X] No [ ]

d. STREET ADDRESS 5600 Arsenal St. St. Louis Chronic Hospital — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First ANNA Middle ROSE Last BUREN

4. DATE OF DEATH Month July Day 11 Year 1958

5. SEX female

6. COLOR OR RACE white

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH Oct. 4, 1874

9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR Months 9 Days 7 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Wilhelm Poepperling

13b. MOTHER'S MAIDEN NAME Gertrude Bauman

14. NAME OF HUSBAND OR WIFE deceased

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. none

17. INFORMANT Mrs. Agnes Fritz Address 3502 N. 14th St.

MEDICAL CERTIFICATION

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

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Generalized Arteriosclerosis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Fracture of Left Hip

DUE TO (c)

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 [ ] NO [X]

20a. ACCIDENT [X] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18) Fall at Chronic Hospital, June 29, 1958.

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 6 29 58

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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.) 13 Hospital

20f. CITY, TOWN, OR LOCATION St Louis COUNTY Mo STATE 000

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at 440 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph M. Quinn Jr. 3

22b. ADDRESS 1300 Clay

22c. DATE SIGNED 7/14/58

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

23b. DATE July 15, 1958

23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis, Missouri

24. FUNERAL DIRECTOR Bromschwig and Son / ADDRESS 4746 W Florissant

25. DATE RECD. BY LOCAL REG. JUL 14 '58

26. REGISTRAR'S SIGNATURE J Carl Smith MD MSB

(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.

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 Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. L

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.