

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-038096
 State File No.

FILED NOV 10 1958

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10152

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or town) St. Louis		c. LENGTH OF STAY (in this place) 1 MO.	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hosp.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) Annie		e. STREET ADDRESS 4714 Louisiana	4. DATE OF DEATH (Month) (Day) (Year) 10-21-58
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow 2	8. DATE OF BIRTH MAY 21 1875
9. AGE (In years last birthday) 83	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? U-S-A	13a. FATHER'S NAME IGNATIUS STOCKLAUSNER	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS ANN HOLSTEIN 4714 LOUISIANA AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) Generalized Arteriosclerosis 1 mo.	
II. OTHER SIGNIFICANT CONDITIONS		Cerebral Arteriosclerosis 1 mo.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 443+	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. HOW DID INJURY OCCUR?
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from 9-25-58, 19__, to 10-21-58, 19__, that I last saw the deceased alive on 10-21-58, 19__, and that death occurred at 12:42 AM from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) John W. Beckham, M.D.		23b. ADDRESS 5800 Arsenal St.	23c. DATE SIGNED 10/21/58
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE OCT 24 1958	24c. NAME OF CEMETERY OR CREMATORY ST. PETER + PAUL CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO
DATE REC'D BY LOCAL REG. OCT 23 1958	REGISTRAR'S SIGNATURE Earl Smith M.D.	25. EMBALMER'S SIGNATURE ADDRESS Thomas Nestor 2906 Gravois	

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.....
James C. White

Licensed Embalmer No. *434*

P. O. Address *2906*

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.