

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038480  
STATE FILE NUMBER

FILED OCT 23 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2669

|                                                                                                                                                                                                                                                    |                           |                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>St. Louis                                                                                                                                                                                                        |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Missouri                                                                                                                                                                                                                                                                                                           |                                                                |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN<br>Lemay                                                                                                                                                                   |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                    | c. CITY OR TOWN<br>St. Louis                                   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br>Mt. St. Rose                                                                                                                                                     |                           | Length of stay in lb<br>8 yrs 9/14/58                                                                                                                                                                                                                                                                                                                                                                                   | d. STREET ADDRESS<br>(If outside, give location)<br>6230 Loran |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>Anna Cash                                                                                                                                                                           |                           |                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. DATE OF DEATH<br>Month Day Year<br>Oct 14 1958              |
| 5. SEX<br>Female / White                                                                                                                                                                                                                           | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                             | 8. DATE OF BIRTH<br>Aug 1 1883                                 |
| 9. AGE (In years last birthday)<br>75                                                                                                                                                                                                              |                           | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                               | IF UNDER 24 HRS.                                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                                                                                                                                           |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Home                                                                                                                                                                                                                                                                                                                                                                               | 11. BIRTHPLACE (City and state or country)<br>Pittsburg Penn / |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                |                           | 13a. FATHER'S NAME<br>Michael Dolka                                                                                                                                                                                                                                                                                                                                                                                     | 13b. MOTHER'S MAIDEN NAME<br>Katherine Pepka                   |
| 14. NAME OF HUSBAND OR WIFE<br>Robert L. Cash<br><del>Edward Cash</del>                                                                                                                                                                            |                           | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                      | 16. SOCIAL SECURITY NO.<br>None                                |
| 17. INFORMANT<br>Address<br>Frances Schroeder 8504 Bryan                                                                                                                                                                                           |                           | 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>Bilateral lower lobe pneumonia</i><br>DUE TO (b) _____<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><i>Metastatic carcinoma from Breast to brain and mediastinum</i> |                                                                |
| INTERVAL BETWEEN ONSET AND DEATH<br><i>1 1/2 days</i>                                                                                                                                                                                              |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                       |                                                                |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                       |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br><i>490X H</i>                                                                                                                                                                                                                                                                                                           |                                                                |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>p.m.                                                                                                                                                                                               |                           | 20d. INJURY OCCURRED WHILE AT WORK<br>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<br>COUNTY STATE                                                                                                                                                                                                                                                                                                                                                                            |                                                                |
| 21. I attended the deceased from <i>July 1951</i> to <i>Oct. 15, 58</i> and last saw her/him alive on <i>Oct. 15, 1958</i><br>Death occurred at <i>8:30 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated. |                           |                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                |
| 22a. SIGNATURE<br>(Degree or title)<br><i>Arthur K. Zuehl MD</i>                                                                                                                                                                                   |                           | 22b. ADDRESS<br><i>7500 Denomshire</i>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                |
| 22c. DATE SIGNED<br><i>10-16-58</i>                                                                                                                                                                                                                |                           | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                              |                                                                |
| 23b. DATE<br><i>Oct 17 58</i>                                                                                                                                                                                                                      |                           | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Resurrection</i>                                                                                                                                                                                                                                                                                                                                                               |                                                                |
| 23d. LOCATION (City, town, or county)<br><i>St. Louis Cty Mo</i>                                                                                                                                                                                   |                           | 24. FUNERAL DIRECTOR<br>ADDRESS<br><i>E. J. Schnur 3125 Lafayette</i>                                                                                                                                                                                                                                                                                                                                                   |                                                                |
| 25. DATE RECD. BY LOCAL REG.<br><i>10-16-58</i>                                                                                                                                                                                                    |                           | 26. REGISTRAR'S SIGNATURE<br><i>Herbert R. Donke M.D.</i>                                                                                                                                                                                                                                                                                                                                                               |                                                                |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Corrected by affidavit 10/23/58

All diseases in Part I must be causally related.

8561 8 4 100  
OCT 2 9 1958

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 *Thomas R. Penwick* .....

Licensed Embalmer No. *3793* .....

P. O. Address *3125 Lafayette* .....

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.