Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003595
STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 456

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Good Samaritan Home — Length of stay in Hospital: 7 1/2 mo
d. STREET ADDRESS (If outside, give location): 5200 So Broadway — Reside on Farm: Yes ☐ No ☑

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 ☑ No ☐

3. NAME OF DECEASED (Type or print): First: ANNA Middle: Last: VORDTRIEDE

4. DATE OF DEATH: Month 1 Day 13 Year 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 7- -1879
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): Alton, Ill
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Robt Graham
13b. MOTHER'S MAIDEN NAME: Isabelle Thorp
14. NAME OF HUSBAND OR WIFE: Otto

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: S. H. Westwood — Address: 530 Monterey Terre Haute Ind

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Chronic myocarditis
DUE TO (c) Gen. Arteriosclerosis + senility
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 422.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
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.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12/11/58, to 1/13/59 and last saw her alive on 1/9/59
Death occurred at 9:40 am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: W. F. Neumann (Degree or title) M.D.
22b. ADDRESS: 5703 Chippewa
22c. DATE SIGNED: 1/14/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1-15-59
23c. NAME OF CEMETERY OR CREMATORY: Zion
23d. LOCATION (City, town, or county): St. Louis Co (State): Mo

24. FUNERAL DIRECTOR: A. Kruse — ADDRESS: 2707 N. Grand
25. DATE RECD. BY LOCAL REG.: JAN 14 '59
26. REGISTRAR'S SIGNATURE: J. Earl Smith MD M.D.

(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 Harvey Kabble

Licensed Embalmer No. 4596

P. O. Address Elmwood

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.