

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015482

STATE FILE NUMBER

2 4040

FILED MAY 11 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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-57

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1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5123a Palm St.		Length of stay in 1b -----	d. STREET ADDRESS (If outside, give location) 5123a Palm Street, Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNA Middle ELIZABETH Last NAU			4. DATE OF DEATH Month April Day 23, Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4th, 1871
9. AGE (In years last birthday) 88		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) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Hermann, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME (Unknown) Heinlein	
13b. MOTHER'S MAIDEN NAME Anna (Unknown)		14. NAME OF HUSBAND OR WIFE Late Louis Nau	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, _____ or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None	17. INFORMANT Josephine Sheller, 5123a Palm Street, Address _____
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Metastatic Carcinoma from Colon to Lung & Abdominal Organ DUE TO (c) Unrelieved Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 3 days - 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Unrelieved Arteriosclerosis 153.8			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <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.)		
20c. TIME OF INJURY .Hour _____ .Month _____ .Day _____ .Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> 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	COUNTY _____ STATE _____
21. I attended the deceased from March 14 '59 to April 23 '59 and last saw her alive on April 23, 1959 Death occurred at 10:10 p.m. in on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature] (Degree or title) M.D.		22b. ADDRESS 4952 Newland Ave	22c. DATE SIGNED 7/24/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/27/59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR'S NAME AND ADDRESS CALVIN F. FEUTZ, 4928 Natural Bridge Blvd., FUNERAL HOME, St. Louis, 15, Missouri		25. DATE RECD. BY LOCAL REG. APR 24 '59	26. REGISTRAR'S SIGNATURE Loal Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

23.6d.

File in City

Friday June

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 *Ralph C. Linder*

Licensed Embalmer No. *4275*

P. O. Address *St. Louis*

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.