Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015735
STATE FILE NUMBER

FILED APR 24 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2.3415

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Anthony Hospital — Length of stay in Ib	d. STREET ADDRESS (If outside, give location) 5625 S. Magnolia Ave. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First / Middle / Last: SISTER MARY ANNUNCIATA			4. DATE OF DEATH Month: Apr. Day: 4 Year: 1959	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Sep. 8, 1882	9. AGE (In years if last birthday): 76 — 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): Nun-Teacher @ St.	10b. KIND OF BUSINESS OR INDUSTRY: Aloysius School	11. BIRTHPLACE (City and state or country): Washington, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME: John H. Droege	13b. MOTHER'S MAIDEN NAME: Maria Eckler	14. NAME OF HUSBAND OR WIFE: ----------		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Sister Mary DeSales — Address: 5625 S.Magnolia		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE LEFT VENTRICULAR FAILURE — 8 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE — —

DUE TO (c) 420.0

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 ☒ 2

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 FEB 1955, to APR 3, 1959 and last saw her/him alive on 31 MAR. 59

Death occurred at 13:00 A. M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: A. R. Hoffmann (Degree or title) M.D.	22b. ADDRESS: 16 Hampton Village Dr.	22c. DATE SIGNED: 4/6/59	
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: Apr. 7, 1959	23c. NAME OF CEMETERY OR CREMATORY: Notre Dame Convent Cemetery	23d. LOCATION (City, town, or county) (State): Lemay, Mo.
24. FUNERAL DIRECTOR: Kriegshauser	ADDRESS: 4228 S.Kingshighway	25. DATE RECD. BY LOCAL REG.: APR 6 '59	26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. MDB

(Licensed Embalmer's Statement on Reverse Side)

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 Richard W. Storrsand

Licensed Embalmer No. 4007

P. O. Address .....

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.