

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015924

STATE FILE NUMBER

2 4164

FILED MAY 15 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms which are listed in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Louis</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Oakville 4000</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>			Length of stay in lb <u>2 days</u>	d. STREET ADDRESS (If outside, give location) <u>Rt. 9, Box 524</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle _____ Last <u>Weiss</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>2 WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 9, 1876</u>		9. AGE (In years last birthday) <u>82</u> 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) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis Co., Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ludwig Taube</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Leopold</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Louis Weiss Rt. 9, Box 438 Mehlville, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>Atherosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>332X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 _____ a.m. _____ p.m.							
20d. INJURY OCCURRED WHILE AT <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 <u>4-21-59</u> to <u>4-26-59</u> and last saw her alive on <u>4-26-59</u> Death occurred at <u>9:30 P.M.</u> m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>A. Grade M.D.</u>			22b. ADDRESS <u>3606 Gravois</u>			22c. DATE SIGNED <u>4-27-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Apr. 29, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Trinity Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lemay, Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>C. Hoffmeister Mortuaries 7014 So. Broadway St. Louis, Mo.</u> (Licensed Embalmer's Statement on Reverse Side)				25. DATE RECD. BY LOCAL REG. <u>APR 28 '59</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u> <u>mdc</u>	

MEDICAL CERTIFICATION

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 *Dice C. Drannon* .....

: Licensed Embalmer No. *4764* .....

P. O. Address *St. Louis, Mo.* .....

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.