RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-030973

FILED VS AUG 26 1959

Registration District No. 317 Primary Registration District No. 543 546 Registrar's No. 2171

STATE FILE NUMBER

DOCUMENT

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Jennings
Length of stay in 1b: 1 mon.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 2610 Winfred
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY:
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 3622 Marcus
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Anna Middle: Last: Dreyer
4. DATE OF DEATH: Month: Aug. Day: 11 Year: 1959
5. SEX: female
6. COLOR OR RACE: white
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 5/5/1890
9. AGE (last birthday): 69 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: 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: home
11. BIRTHPLACE (City and state or country): St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Patrick Grahm
13b. MOTHER'S MAIDEN NAME: Anna Schmidt
14. NAME OF HUSBAND OR WIFE: John Dreyer
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: Bernard Dreyer Address: 3622 Marcus

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): Auricular Fibrillation
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertension
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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

BY AFFIDAVIT OF

21. I attended the deceased from Sept 1958 to Aug 1959 and last saw her him alive on Aug 5 1959
Death occurred at 1:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Alonzo A. Wild M.D.
22b. ADDRESS: 3901 W. Florissant
22c. DATE SIGNED: 8/12/59
23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 8/14/1959
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Mo.
24. FUNERAL DIRECTOR ADDRESS: Buchholz Mort. 5967 W. Florissant Av.
25. DATE RECD. BY LOCAL REG.: 8-13-59
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.