

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS OCT 23 1959

59-037796

STATE FILE NUMBER

2 9484

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>		Length of stay in 1b		c. CITY OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>FIRMIN DESLOGE Hosp.</i>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <i>3319 CALIFORNIA</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <i>ANNA</i> Middle Last <i>LANDLER</i>				4. DATE OF DEATH Month <i>OCT</i> Day <i>14</i> Year <i>1959</i>									
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>AUG. 9 1884</i>		9. AGE (last birthday) <i>75</i>		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) <i>HOUSEWIFE</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state of country) <i>ST. LOUIS, Mo</i>		12. CITIZEN OF WHAT COUNTRY <i>U. S. - A.</i>					
13a. FATHER'S NAME <i>ADOLPH KAERNBACH</i>				13b. MOTHER'S MAIDEN NAME <i>ALBERTINA NOVACK</i>				14. NAME OF HUSBAND OR WIFE (DECD) <i>NICKOLAS LANDLER</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16. SOCIAL SECURITY NO. <i>498-05-9866^a</i>		17. INFORMANT <i>AGNES WEICK</i>		Address <i>3835 S. Spring</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>										<i>8 hrs.</i>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arterio sclerotic coronary artery</i>													
DUE TO (c) <i>heart disease</i>										<i>4201</i>			
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		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. Month, Day, Year													
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 <i>10-8-59</i> to <i>10-14-59</i> and last saw her alive on <i>10-14-59</i> Death occurred at <i>4:30 P.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>J. H. Willman, M.D.</i>						22b. ADDRESS <i>1325 S. Grand</i>				22c. DATE SIGNED <i>10-16-59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		23b. DATE <i>OCT. 17 1959</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PARK LAWN Cem.</i>				23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Co., Mo</i>					
24. FUNERAL DIRECTOR <i>Thomas Kutek</i>				ADDRESS <i>2906 Spruce</i>		25. DATE RECD. BY LOCAL REG. <i>OCT 16 59</i>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> <i>S.P.</i>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *James E. White*

Licensed Embalmer No. 4347

P. O. Address 2906 _____

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.