

FILED VS MAR 24 1960

2 2832

STATE FILE NUMBER

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>INCARNATE WORD Hosp.</i>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>3504 WYOMING</i>	
3. NAME OF DECEASED (Type or print) First <i>ANNA</i> Middle <i>CROSS</i> Last				4. DATE OF DEATH Month <i>MAR.</i> Day <i>8</i> Year <i>1960</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>JULY 26 1974 85</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WIDOW</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (City and state or country) <i>Mo</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>WILLIAM KUNES</i>				13b. MOTHER'S MAIDEN NAME <i>ANNA TIKWORT</i>		14. NAME OF HUSBAND OR WIFE <i>ALBERT CROSS (DEC'D)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>JOHN CROSS</i> Address <i>3504 Wyoming</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, Hypostatic Bilateral</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <del>DOE TO (b) <i>Angerine, left by due to Arteriosclerosis</i></del> <del>DOE TO (c) <i>Hemiplegia, Rt due to Arteriosclerosis</i></del>							INTERVAL BETWEEN ONSET AND DEATH <i>48 hr</i> <i>1 week</i> <i>3 years</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 checked="" 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>1/12/58</i> , to <i>3/8/60</i> and last saw her <i>alive</i> on <i>3/8/60</i> Death occurred at <i>10:15 pm</i> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>James J. Stephens</i>				22b. ADDRESS <i>2207 So Grand Ave</i>		22c. DATE SIGNED <i>3/10/60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BORIAL</i>		23b. DATE <i>MAR. 11 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>S.S. Peter &amp; Paul</i>		23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo</i>	
24. FUNERAL DIRECTOR <i>Thomas Kuter</i> ADDRESS <i>2906 Georgia</i>				25. DATE RECD. BY LOCAL REG. <i>MAR 11 1960</i>		26. REGISTRAR'S SIGNATURE <i>Loan Smith. M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

S.P.

event 2.20

**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 C. Hill

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.