

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033260

FILED VS  
ENDED

SEP 12 1960  
Registration District No. 317

Primary Registration District No. 547

Registrar's No. 2493

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Length of stay in 1b <b>8 weeks</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4709 San Francisco Av.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>M.</b> Last <b>HOLWELL</b>				4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>1960</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8-31-1890</b>		9. AGE (last birthday) <b>69</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Peter Maurer</b>			13b. MOTHER'S MAIDEN NAME <b>Julia Zahnleiter</b>			14. NAME OF HUSBAND OR WIFE <b>William J. Holwell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Wm. J. Holwell, 4709 San Francisco</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vas. Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Atherosclerosis</b> DUE TO (c) 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							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hr.</b>		
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 Month, Day, Year a.m. p.m.		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 <b>8/17/60</b> to <b>8/21/60</b> and last saw her <input checked="" type="checkbox"/> alive on <b>8/21/60</b> Death occurred at <b>11:20 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree & title) <b>W. A. Knight M.D.</b>				22b. ADDRESS <b>4161 Lindell Blvd. St. Louis 8 Mo.</b>			22c. DATE SIGNED <b>8/22/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Aug. 24, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>			
24. FUNERAL DIRECTOR <b>Morrell Funeral Home, 3710 No. Grand.</b>				25. DATE RECD. BY LOCAL REG. <b>8-22-60</b>		26. REGISTRAR'S SIGNATURE <b>J. M. Murphy M.D.</b>			

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W E Morris

Licensed Embalmer No. 330

P. O. Address St Joe

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.

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