

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. SEP 21 1960 318

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9024

=60-036049

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)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Pine Lawn	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Faith Hospt.		d. STREET ADDRESS (If outside, give location) 6229 Vetter Pl.	

3. NAME OF DECEASED (Type or print) First Middle Last Anna M DeGrande			4. DATE OF DEATH Month Day Year 9-12-60		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-5-1888	9. AGE (last birthday) 72	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) Self Emp.		10b. KIND OF BUSINESS OR INDUSTRY Trailer Court	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME Bert. Engels		13b. MOTHER'S MAIDEN NAME UNK		14. NAME OF HUSBAND OR WIFE Edward T DeGrande Dec.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. UNK		17. INFORMANT Address Edward DeGrande 6229 Vetter Pl.	

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) Acute Coronary Occlusion			Sudden
DUE TO (b) arteriosclerotic Hypertensive cardiovascular disease			year
DUE TO (c) 4201			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Diabetes mellitus			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 St. Louis	COUNTY St. Louis	STATE
21. I attended the deceased from 5/19/53 to 9/12/60 and last saw her/him alive on 9/1/60 Death occurred at 9:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) Robert A. Bauer MD		22b. ADDRESS 3731 Goodfellow		22c. DATE SIGNED 9/12/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-15-60	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri	

24. FUNERAL DIRECTOR ADDRESS J.W. Clark F.H. 1125 Hodiamont Ave.	25. DATE RECD. BY LOCAL REG. SEP 13 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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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 Alfred J. Breakey

Licensed Embalmer No. 266

P. O. Address 1125 Hillside

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