

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-015890

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1198

AMENDED

FILED MAY 8 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		c. CITY OR TOWN <u>KIRKWOOD MO</u>	
Length of stay in 1b <u>DAYS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST Louis Co Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>317 So KIRKWOOD RD</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>FRITSCHE</u> Last <u></u>			4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1961</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-13-1896</u>
9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>St Louis Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Schallon</u>	
13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Joseph</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Joseph</u>		Address <u>Mo 317 So Kirkwood Kirkwood</u>	
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) <u>Pulmonary Edema</u>			<u>48 h.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Anasarca</u>			<u>4 months</u>
DUE TO (c) <u>Cardiac Decompensation & Edema</u>			<u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>In Situ</u>			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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>4-6-61</u> to <u>4-28-61</u> and last saw her alive on <u>4-25-61</u> Death occurred at <u>12:30</u> <u>A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. John W. Wilkinson DO.</u>		22b. ADDRESS <u>445 S. Main St. St. Clair Mo</u>	22c. DATE SIGNED <u>4-28-61</u>
23a. BURIAL, CREMATION, OR OTHER DISPOSITION <u>BURIAL</u>	23b. DATE <u>4/30/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEGAR Hill Baptem</u>	23d. LOCATION (City, town, or county) (State) <u>CEGAR Hill MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>BRIMMER FUNERAL Home House Springs Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-29-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>

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 Herbert J. Gen Jr.

Licensed Embalmer No. 4800

P. O. Address Hickwood 277

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.