SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5137 STATE FILE NUMBER -61-018788

FILED JUN 8 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

1: PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 1 yr. 2 mo 28 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Chronic Hosp.
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4242 W. Pine St.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: George Middle: Last: Annan
4. DATE OF DEATH: Month Day Year: 5-31-61
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 9-26-1882
9. AGE (last birthday): 78
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): Londscaper
10b. KIND OF BUSINESS OR INDUSTRY: City of St.Louis
11. BIRTHPLACE (City and state or country): Pilot Grove, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: William Rowe Annan
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: deceased
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none
17. INFORMANT: Robert S.Annan Address: 155 Martigney Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic cor pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Asthma — 50 yrs
DUE TO (c) 241x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Uremia due to prostatic obstruction
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 3-2-60 to 5-31-61 and last saw her/him alive on 5-31-61
Death occurred at 9:35 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Decedent's Attendant or Coroner): Kenneth C Price M.D.
22b. ADDRESS: 5600 Arsenal
22c. DATE SIGNED: 5/31/61
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 6-2-1961
23c. NAME OF CEMETERY OR CREMATORY: Walnut Hill Cemetery
23d. LOCATION (City, town, or county) (State): Belleville Illinois
24. FUNERAL DIRECTOR: Fendler Und.Co. ADDRESS: 7420 Michigan Ave.
25. DATE RECD. BY LOCAL REG.: JUN 1 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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_____ Signed W. S. Peterson

Signature of Student Embalmer

Licensed Embalmer No. 3747

P. O. Address 7420 Mi

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.