

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-017239

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3744

FILED APR 25 1962

1. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in "b" _____
 c. CITY OR TOWN St. Louis Inside Limits? Yes No
 c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Chronic Hospital Inside Limits Yes No
 d. STREET ADDRESS (if outside, give location) 1315 N. 7th St. Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
Anna Schreckler April 6, 1962

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 10/22/1867 9. AGE (last birthday) 94 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework 10b. KIND OF BUSINESS OR INDUSTRY At Home 11. BIRTHPLACE (City and state or country) Marshall, Mo. 12. CITIZEN OF WHAT COUNTRY U.S.

13a. FATHER'S NAME Bohrer 13b. MOTHER'S MAIDEN NAME Schreckler 14. NAME OF HUSBAND OR WIFE None

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. None 17. INFORMANT Gail Stampfli, 168 Harvington Dr. Rochester, N.Y. Address _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ DUE TO (b) 4200
 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. 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____

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 1960 to present and last saw her 6 Apr 62 and to the best of my knowledge, from the causes stated. Death occurred at 5:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph B. Crust M.D. 22b. ADDRESS 5600 Arsenal 22c. DATE SIGNED APR 9 1962

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 4-9-62 23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery 23d. LOCATION (City, town, or county) (State) Jefferson City, Mo.

24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd. ADDRESS _____ 25. DATE RECD. BY LOCAL REG. APR 9 1962 26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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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 Guy W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address St Louis, Mo

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.