

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-003860
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
AMENDED

VS 300 Rev. 4/59	DATE AMENDED
1	
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
50
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 962

FILED FEB 8 1963

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b- _____
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Brothers Hospital 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) 3140A California Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First ANNA Middle B Last MEINHARDT 4. DATE OF DEATH Month January Day 27 Year 1963

5. SEX female 6. COLOR OR RACE white 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 8/10/1877 9. AGE (last birthday) 85 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) at home 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) Columbia, Missouri 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME George Schmidt 13b. MOTHER'S MAIDEN NAME not known 14. NAME OF HUSBAND OR WIFE Fred

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 Address Frieda Laumann 3145 California

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cerebral Hemorrhage into Left Hemisphere
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Left Hemiplegia
DUE TO (c) Arterio-sclerotic Heart Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0
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 Dec 23-62 to Jan 27-63 and last saw her alive on Jan 27-1963. Death occurred at 6:10 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title) MD 22b. ADDRESS 3606 Adams St 22c. DATE SIGNED 1/28/63

23a. BURIAL, CREMATION, REMOVAL (Specify) removal 23b. DATE 1/30/1963 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Churchyard 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

24. FUNERAL DIRECTOR John L Ziegenhein & Sons ADDRESS 7027 Gravois 25. DATE RECD. BY LOCAL REG. JAN 29 1963 26. REGISTRAR'S SIGNATURE Paul Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

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

C. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 70 27 Graves

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.