

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

13017

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City..... (No. ....)

File No. ....

Registered No. **3305**

St. ....

Ward

**2. FULL NAME**

*Edward Husslein*

(a) Residence No. **3311 Sheppard St.**

**17** Ward.

(Usual place of abode)

(If nonresident of town and State)

Residence in city or town where death occurred yrs. mos. ds.

How long in U.S., if of foreign birth yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **M**

4. COLOR OR RACE **White**

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Gretchen Husslein**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept 18-1867**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<b>59</b>	<b>6</b>	<b>17</b>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **Huckster**

(b) General nature of industry, business, or establishment in which employed (or employer) **self**

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) **Germany**

10. NAME OF FATHER **Not Known**

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT **Karl Husslein**

(Address) **2131 Illinois**

15. FILED **APR - 6 1927** **Man C. Starkeoff** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 5 1927**

17. I HEREBY CERTIFY That I attended deceased from **Apr 5 1927**, to **Apr 5 1927** that I last saw **him** alive on **Apr 5 1927** and that death occurred, on the date stated above, at **239 1/2** m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Embolism of heart**

CONTRIBUTORY **Diabetes mellitus** (SECONDARY)

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Ex. of urine**

(Signed) **Sam H. Zimmer**, M. D.

**Mar 5, 1927** (Address) **2134 Grand**

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDE.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

DATE OF BURIAL

**Falshalla**

**April 7 1927**

**20. UNDERTAKER**

ADDRESS

**Rauerk Schmidt** **3732 8th**

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

10/10/10

10/10/10

10/10/10