

S. No. 2
M-2-43
5-17-39
-1 X35637

FILED FEB 27 1944
Registration District No. 318

Primary Registration District No. 1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4486 Penrose St. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: in hospital or institution None
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17

(c) City or town St. Louis 9/0
(If outside city or town limits, write "RURAL")

(d) Street No. 4486 Penrose St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Catherine M. Huss

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 16th
year 1944 hour 10:30 minute _____ M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frank X Huss

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased January 23, 1891
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 16th 1943 to Jan 16th 1943
that I last saw him alive on Jan 16th 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Gangrene - Fractured
Both limbs from

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>11</u>	<u>24</u>	hr. _____ min. _____

Due to Diabetes Mellitus (Insulin) for some years ago.

Due to Home treatment no physician until few hours before death.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

Other conditions Diabetic Coma due to gangrene absorption

Major findings: To gangrene absorption

Of operations _____

Of autopsy _____

MOTHER FATHER

12. Name Joseph Hepp

13. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Kessler

15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Frank X. Huss

(b) Address 4486 Penrose St.

17. (a) Burial (b) Date thereof 1/20/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave

19. (a) JAN 19 1944 (b) J. F. Burdick
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Chas. Taylor (M. D. or other) _____
Address 4244 W. Pleasant Date signed 1/24/44

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *William G. Buchholz*

Licensed Embalmer No. *2110*

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 this body is not embalmed, fact should be so stated above.