

S. No. 2
M-2.43
5-17-39

X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8278

FILED FEB 19 1944

State File No. _____

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 366

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days
(Specify whether

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Riverview Gardens
(If outside city or town limits, write "RURAL")

(d) Street No. 427 Bluff Dr.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles Hulsman

3. (b) If veteran, name war --

3. (c) Social Security No. ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2-9-44 day _____
year _____ hour 1:45 minute _____ P. M.

21. I hereby certify that I attended the deceased from 2-5-44, 19____, to 2-9-44, 19____;
that I last saw him alive on 2-9-44, 19____;
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced Wid.

6. (b) Name of husband or wife Mary Hulsman (Dec.) 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased 10-9-1862
(Month) (Day) (Year)

Immediate cause of death Cerebral artery thrombosis Duration 6 days

8. AGE: Years Months Days If less than one day

81	4	0	hr. _____ min.
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Due to Atherosclerosis

Due to _____

9. Birthplace Elberfield Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation None FARMER

Other conditions Pneumonia
(Include pregnancy within 3 months of death)

11. Industry or business ---

MOTHER FATHER { 12. Name Unknown

13. Birthplace Unknown unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown unknown
(City, town, or county) (State or foreign country)

Major findings: Of operations none \$35.00

Of autopsy Thromboses of arteries in brain

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Nellie Palmer

(b) Address 427 Bluff Dr.

17. (a) Removal (b) Date thereof FEB-14 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DEXTER MO. CEM.

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? _____

18. (a) Signature of funeral director Diedrich T. Jones

(b) Address 8319 Halla Keaney Rd

19. (a) FEB 14 1944 (b) E. J. McLaughlin
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury 0

23. Signature James G. Owen (M. D. or other) M.D.

Address 601 Brentford Blvd, Clayton Date signed 2-11-44

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.....

Arthur M. Deedrich

Licensed Embalmer No.....

3536

P. O. Address.....

St Louis

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.