

FILED OCT 6 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, Missouri
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 1 mo - 9 days
(Specify whether years, months or days) 0

3. (a) PRINT FULL NAME Frank Hussman

3. (b) If veteran, name war None

3. (c) Social Security No. 491-18-1324

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mathilda Hussmann

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

7. Birth date of deceased September 18 1867
(Month) (Day) (Year)

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

77 0 9 hr. _____ min.

9. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Night Watchman and Porter
Theiling & Lothman Planing Mill

MOTHER FATHER

11. Industry or business Frank Hussmann

12. Name Unknown

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

14. Maiden name Catherine Unknown

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

16. (a) Informant Mrs. Katherine Thomas

(b) Address Burlington, Iowa

17. (a) Burial (b) Date thereof 9-30-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) SEP 29 1944 (b) J. F. Biedeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mo

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17 26

(d) Street No. 3600 N. 9th St.
(If rural, give location) 1

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

If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27th
year 1944 hour 1:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from 8/14/44
_____ 19____ to Sept. 27th 19 44
that I last saw h. im alive on Sept. 27th 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Atherosclerosis, cerebral + generalized

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 97

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

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? _____

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature K. R. Schledeman (M. D. or other) 9/27/44
1515 Lafayette Date signed

Address _____

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 *W. Wilkinson*

Licensed Embalmer No. 3575

P. O. Address.....

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.