

V. S. No. 2
FORM-8-43
Rev. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 23 1944 18

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32436

State File No. _____

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 8732

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:
8629 Montgomery St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL") 950
(d) Street No. 2629 Montgomery St.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William F. Hussmann
3. (b) If veteran, name war _____ 3. (c) Social Security No. 489-18-2510

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 9 8 1877
(Month) (Day) (Year)

8. AGE: Years 67 Months 3 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name William Hussmann
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Catherine Schneider
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mable Hagner, daughter

(b) Address 8629 Montgomery St.

17. (a) burial (b) Date thereof 10/16/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery.

18. (a) Signature of funeral director Sullivan Brothers.

(b) Address 2849 North Euclid Avenue.

19. (a) OCT 23 1944 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 13th
year 1944 hour 2:10 minute _____ P. M.
21. I hereby certify that I attended the deceased from Feb 1930, 1930, to October 13, 1944;
that I last saw him alive on OCT. 12, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchitis Chronica Duration _____
Bronchial Asthama
Due to Arteriosclerosis

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death) 1/2

Major findings:
Of operations _____
Of autopsy No

PHYSICIAN
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 J. J. Meredith (M. D. or other) MD
Address 1257 N. Kinross Highway Date signed 10-13-44

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

Dr. J. J. Meredith

1259 N. Kingshighway
Ft. 0047

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 Eugene H. Sullivan

Licensed Embalmer No. # 2930

P. O. Address St. Louis, Missouri,

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.