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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 1 1945 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Registration District No. Primary Registration District No. **1003**

State File No. **25567**
Registrar's No. **7447-**

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

1. PLACE OF DEATH:
(a) County St. Louis Mo
(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Barnes Hospital, O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Hulu Deuschle
3. (b) If veteran, name war Nil 3. (c) Social Security No. None
4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased January 17 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 7 8 hr. min.

9. Birthplace Clifford County Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Housekeeper

11. Industry or business _____
12. Name Adam Deuschle
13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)
14. Maiden name Kathryn Unknown
15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. John Denham
(b) Address 6233a Wagoner Pl.

17. (a) Burial (b) Date thereof 8-28-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Pilot Grove, Missouri

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) AUG 27 1945 (b) J. F. Bradach
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Clifford **99**
(c) City or town Pleasant Green
(If outside city or town limits, write "RURAL") **N.R.**
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 25
year 45 hour 9 minute P. A.M.
21. I hereby certify that I attended the deceased from August 14, 1945, to August 25, 1945
that I last saw h. er alive on August 25, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death CACHEXIA of Pulmonary E. Dem.
Due to Adeno carcinoma

Due to _____
Other conditions Biliary Fistula - Post operative
(Include pregnancy within 3 months of death)

Major findings: abdominal carcinoma
Of operations _____
Of autopsy SS
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) (e) Means of injury _____
23. Signature J. F. Bradach (M. D. or other) _____
Address Barnes Hospital, Date signed 8-26-45

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

Elmer R. Sedwell

Licensed Embalmer No. *4077*

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.