

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 1 1949

1002

State File No. 10208
2583

318

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN _____		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN _____		17	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____			
De Paul Hospital		3 days		St. Louis Mo.		4203 Harris Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year)				
Ann. Hussey			Mar. 20 1949				
5. SEX _____	6. COLOR OR RACE _____	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____	8. DATE OF BIRTH _____	9. AGE (In years last birthday) _____	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
Female	White	Widow	May 24, 1864	84			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) _____		12. CITIZEN OF WHAT COUNTRY? _____
Housework					St. Louis, Mo.		
13a. FATHER'S NAME _____		13b. MOTHER'S MAIDEN NAME _____		14. NAME OF HUSBAND OR WIFE _____			
Pat Mathews		Mary Hally		George Hussey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____			
No		None		Frances Gastorf, 4203 Harris			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 4 yrs
		Crown heart disease					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from Dec 21, 1947, to March, 1948, that I last saw the deceased alive on March 15, 1949, and that death occurred at 7:45 a.m., from the causes and on the date stated above.							
23a. SIGNATURE _____ (Degree or title) _____				23b. ADDRESS _____		23c. DATE SIGNED _____	
J. B. Susater				534 S. Grand		3-22-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE _____		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) _____ (State) _____	
Burial		Mar. 23, 1949		Calvary		St. Louis, MO.	
DATE REC'D BY LOCAL REG. _____		REGISTRAR'S SIGNATURE _____		25. FUNERAL DIRECTOR'S SIGNATURE _____		ADDRESS _____	
MAR 22 1949		J. B. Susater		J. J. Quinn		1389 Union Blv'd	

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

Dr. Vourna
537 H Dr

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Ronald G. Kunkle

Signed _____
Student Embalmer

Licensed Embalmer No. 3917

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.