

FILED JAN 3 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42605  
10973

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>7 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DePaul Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>20 3416 Klein St.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Raymond</u>			b. (Middle) <u>George</u>		c. (Last) <u>Huschle</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 21, 1949</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <u>Married</u>	8. DATE OF BIRTH <u>Dec. 3, 1902</u>		9. AGE (In years last birthday) <u>47</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cattle Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Watkins &amp; Co.</u>		11. BIRTHPLACE (State or foreign country) <u>E. St. Louis, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		
13a. FATHER'S NAME <u>Joseph Huschle</u>			13b. MOTHER'S MAIDEN NAME <u>Nina Morris</u>		14. NAME OF HUSBAND OR WIFE <u>Eleanor Huschle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Eleanor Huschle</u> ADDRESS <u>St. Louis, Mo.</u>				
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Portal Cirrhosis</u>  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. <u>Esophageal Varix ruptured</u>				INTERVAL BETWEEN ONSET AND DEATH.
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) <u>St. Louis, Mo.</u>				
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? <u>5810</u>				
22. I hereby certify that I attended the deceased from <u>12/12, 1949</u> , to <u>12/21, 1949</u> that I last saw the deceased alive on <u>12/20, 1949</u> , and that death occurred at <u>EA</u> m., from the causes and on the date stated above.								
23a. SIGNATURE <u>L. Hayden M. D.</u> (Degree or title)				23b. ADDRESS <u>5899 Delmar</u>		23c. DATE SIGNED <u>12/21/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Dec. 21, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		24d. LOCATION (City, town, or county) (State) <u>Belleville, Illinois</u>		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>DEC 21 1949 J. B. Foster</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Keady</u> ADDRESS <u>'E. St. Louis, Ill.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

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**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.....

Signed.....  
Student Embalmer

Licensed Embalmer No.....

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.