

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18960**

FILED JUN 3 1950

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **1221**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) Manchester	c. LENGTH OF STAY (In this place) 2 Months	c. CITY (If outside corporate limits, write RURAL and give township) 2157 OR TOWN St Louis Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION Manchester Nursing Home		d. STREET ADDRESS (If rural, give location) 15 3409 1/2 Meramec	

3. NAME OF DECEASED (Type or Print) Theodore E Haussner			4. DATE OF DEATH (Month) (Day) (Year) 5 - 12 - 50		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH 12-9-1891		9. AGE (In years last birthday) 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME Theodore Haussner	13b. MOTHER'S MAIDEN NAME Not Known	14. NAME OF HUSBAND OR WIFE Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME T.E. Haussner		ADDRESS 10453 San Carl Lane
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Carcinomatosis	DUPLICATE		1 yr
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUPLICATE (b) Ca of large bowel		1 yr
DUPLICATE (c) _____	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		153X

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? 153X YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) _____
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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? 153X
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22. I hereby certify that I attended the deceased from **Mar 10, 1950**, to **May 12, 1950**, that I last saw the deceased alive on **May 19, 1950**, and that death occurred at **4:30 A. M.**, from the causes and on the date stated above.

23a. SIGNATURE Chas Denny (Degree or title) MD	23b. ADDRESS Creve Coeur, Mo	23c. DATE SIGNED 5-12-50
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24a. BURIAL, CREMATION, OR REMOVAL (Specify) Crema	24b. DATE 5-12-50	24c. NAME OF CEMETERY OR CREMATORY Resurrection	24d. LOCATION (City, town, or county) (State) St Louis Mo
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAY 13 1950	REGISTRAR'S SIGNATURE Robert H. Blanke	25. FUNERAL DIRECTOR'S SIGNATURE Donnermiller	ADDRESS 3819 S Grand Blvd.
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(Licensed Embalmer's Statement on Reverse Side)

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

REC'D JUN 6 1954

JUN 3 1954

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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....

George J. Mybermehle

Signed.....

Student Embalmer

Licensed Embalmer No. 4611

P. O. Address St Louis

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.