

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 24 1950

State File No. 38645  
9650  
Registrar's No.

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		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) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2179			
d. FULL NAME OF HOSPITAL OR INSTITUTION 4159A FLAD AV.		d. STREET ADDRESS (If rural, give location) 1944 LOUISIANA AV.					
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) A. c. (Last) HURSTER.			4. DATE OF DEATH (Month) (Day) (Year) Nov. 12-50				
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W. Y.		8. DATE OF BIRTH JAN 7-1860	9. AGE (In years last birthday) 90 YRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY LAUNDRY		11. BIRTHPLACE (State or foreign country) Missouri			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John HURSTER		13b. MOTHER'S MAIDEN NAME unknown			
14. NAME OF HUSBAND OR WIFE MARY HURSTER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.			
17. INFORMANT'S SIGNATURE OR NAME Loretta Hurster		18. ADDRESS 1944 Louisiana Av.					
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) Acute cardiac failure  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis Heart Disease DUE TO (c) Benign Hypertension  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H200			
22. I hereby certify that I attended the deceased from 10 - 10:45 to 11-12, 1950, that I last saw the deceased alive on 6-15, 1950, and that death occurred at 9:40 p.m., from the causes and on the date stated above.							
23a. SIGNATURE Elinor P. Scott M.D.		23b. ADDRESS 3258 Lafayette		23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE NOV-15-50		24c. NAME OF CEMETERY OR CREMATORY CALVARY Cem.			
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		24e. DATE, REC'D BY LOCAL REG. Nov 24 1950		24f. REGISTRAR'S SIGNATURE J. B. Luster			
25. FUNERAL DIRECTOR'S SIGNATURE Er. J. Schmur		25. ADDRESS 3125 Lafayette av					

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.....

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.