

FILED SEP 1 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28361

7371

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2179	
c. LENGTH OF STAY (in this place) 12 Days		d. STREET ADDRESS (If rural, give location) 3802 McRee Avenue 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital			

3. NAME OF DECEASED (Type or Print) DAVID		a. (First) ALBERT	b. (Middle) HUGHES	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 8 17 1951	
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11/25/1880	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months 8	IF UNDER 1 YEAR Hours 22	IF UNDER 1 MIN. Hours
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dep. t Mgr.	10b. KIND OF BUSINESS OR INDUSTRY Meyer Drug Co	11. BIRTHPLACE (State or foreign country) Ft. Wayne Indiana	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME David R. Hughes	13b. MOTHER'S MAIDEN NAME Mary Evans	14. NAME OF HUSBAND OR WIFE Hildegard Wienhagen
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 494-07-1990A	17. INFORMANT'S SIGNATURE OR NAME Mrs. Wm. Cullinane	ADDRESS 6445 San Bonita
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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, asthma, 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) Metastatic Ca Abdomen		3 mo
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ca of Rectum DUE TO (c)		6 mo
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? 154X
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22. I hereby certify that I attended the deceased from Mar, 1951, to 8/17/51, 19, that I last saw the deceased alive on 8/17/51, 19, and that death occurred at 11:30A, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M.D. 23b. ADDRESS 4952 Maryland	23c. DATE SIGNED 8/17/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE 8/20/51	24c. NAME OF CEMETERY OR CREMATORY Valhalla Creamatory	24d. LOCATION (City, town, or county) (State) St. Louis County Missouri
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 18 1951	25. FUNERAL DIRECTOR'S SIGNATURE Ambruster Mortuary	ADDRESS 6633 Clayton Road
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(Licensed Embalmer's Statement on Reverse Side)

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

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

Roland O Yohruke

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.