

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29060**

FILED SEP 15 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **3122**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis Co.</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Wellston</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>30 TOWN Wellston</b>	
c. LENGTH OF STAY (in this place) <b>4301</b>		d. STREET ADDRESS (If rural, give location) <b>6523 Mount Ave.,</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>6523 Mount Ave.,</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>RUDOLPH</b>	b. (Middle) <b>L.</b>	c. (Last) <b>LUSCH.</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 10, 1951.</b>
-------------------------------------	---------------------------	-----------------------	-------------------------	-----------------------------------------------------------------

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 12, 1888.</b>	9. AGE (In years last birthday) <b>62</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	-----------------------------------------------------------------------	----------------------------------------	-------------------------------------------	-----------------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Decorator</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Ferdinand, Ind.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
-----------------------------------------------------------------------------------------------------------------	-----------------------------------	---------------------------------------------------------------------	---------------------------------------------

13a. FATHER'S NAME <b>Anthony Lusch</b>	13b. MOTHER'S MAIDEN NAME <b>Cecelia Schnider</b>	14. NAME OF HUSBAND OR WIFE <b>Rose Lusch wife</b>
--------------------------------------------	------------------------------------------------------	-------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Rose Lusch 6523 Mount Ave.,</b>	ADDRESS
-----------------------------------------------------------------------------	----------------------------------	-------------------------------------------------------------------------	---------

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, ashenia, 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) <b>Cerebral accident</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Laber pneumonia</b> DUE TO (c) <b>490X</b>		
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"/>
------------------------	----------------------------------	-------------------------------------------------------------------------------------

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?
------------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from **July 1915** to **Sept 10, 1951**, that I last saw the deceased alive on **Sept 10, 1951**, and that death occurred at **6:10 P.M.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Thomas M. Davis, M.D.</b>	23b. ADDRESS <b>2422 N. Grand Bl</b>	23c. DATE SIGNED <b>9/11/51</b>
------------------------------------------------------------------	-----------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Sept. 13/51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
------------------------------------------------------------	---------------------------------	-----------------------------------------------------------	------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <b>9-11-51</b>	REGISTRAR'S SIGNATURE <b>Berbert R. Donk M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. W. Clark</b>	ADDRESS <b>1125 Hodiamont Ave.,</b>
--------------------------------------------	------------------------------------------------------	----------------------------------------------------------	----------------------------------------

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

D<sup>r</sup>. Thomas M. Davis,  
2424 N. Grand Blvd.,  
FR. 4325  
2-4 P.M.

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.

Student .....  
Student Embalmer

Signed

*John J. Haines*

Licensed Embalmer No. *4108*

P. O. Address *St. Louis Mo*

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.