

FILED DEC 15 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 39173  
Registrar's No. 10998

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 10998	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		2269	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1504 a Destrehan St.</u>				d. STREET ADDRESS (If rural, give location) <u>1504 a Destrehan St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) _____ c. (Last) <u>Huber</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>12 11 51</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>11-8-1874</u>	
9. AGE (In years last birthday) <u>77</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>0</u>		13a. FATHER'S NAME <u>Michael Daily</u>		13b. MOTHER'S, MAIDEN NAME <u>Mary Daily</u>		14. NAME OF HUSBAND OR WIFE <u>Jack Huber</u>	
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. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Loretta Barnes</u> ADDRESS <u>1504 a Destrehan</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Degeneration</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Haemorrhage slight.</u> DUE TO (c) <u>Arterial Hypertension.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>3 wks.</u> <u>2 yr.</u>	
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>331-X</u>			
22. I hereby certify that I attended the deceased from <u>Nov 15, 1951</u> to <u>Dec 10, 1951</u> , that I last saw the deceased alive on <u>Dec 10, 1951</u> , and that death occurred at <u>12:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>J. D. Puckler M.D.</u>				23b. ADDRESS <u>2505 No. Delmar</u>		23c. DATE SIGNED <u>12-11-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-13-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo</u>	
DATE REC'D BY LOCAL REG. <u>DEC 12 1951</u>		REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Goohart &amp; Goodhart</u> ADDRESS <u>2228 St. Louis, Av</u>			

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*John S. Bennett*

Licensed Embalmer No. 4194

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.