

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39407**

Registrar's No. **10817**

FILED DEC 15 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2139	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary		d. STREET ADDRESS (If rural, give location) 13 5800 Arsenal St.	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) c. (Last) Maser			4. DATE OF DEATH (Month) (Day) (Year) Dec. 5 1951
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Apr. 8, 1888
9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY ---	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Henry Maser		13b. MOTHER'S MAIDEN NAME Caroline Schuerman	14. NAME OF HUSBAND OR WIFE ---
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS City Inf. record. 5800 Arsenal St
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular.		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
DUE TO (b) Cerebral Anoxia.		DUE TO (c)	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		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 checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) SUICIDE HOMICIDE	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? 331X	
22. I hereby certify that I attended the deceased from 10-2 , to Dec. 5 , 19 51 , that I last saw the deceased alive on Dec. 5 , 19 51 , and that death occurred at 6:00 AM from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Polina Pusina Polish N.Y.		23b. ADDRESS City Infirmary Hospital	23c. DATE SIGNED 12-5-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/8/51	24c. NAME OF CEMETERY OR CREMATORY N. St. Marcus Cem.	24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
DATE REC'D BY LOCAL REG. DEC 6 1951	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacker-Heldrele 3634 Gravois	

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 _____

Licensed Embalmer No. 2645

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.