

No. 200
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11453

State File No.

FILED MAR 19 1952

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 326

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay	c. LENGTH OF STAY (in this place) 31 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay 85	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3617 Lemay Ferry Road		d. STREET ADDRESS (If rural, give location) 3617 Lemay Ferry Road 0	

3. NAME OF DECEASED (Type or Print) SOPHIE a. (First) *** b. (Middle) LUDEWICK c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Feb. 6, 1952			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 31, 1880	9. AGE (In years last birthday) 71	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) Housework		10b. KIND OF BUSINESS OR INDUSTRY At. Home	11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? /	

13a. FATHER'S NAME Joseph Pflueger		13b. MOTHER'S MAIDEN NAME Sophie Hess		14. NAME OF HUSBAND OR WIFE Theodore E. Ludewick	
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 Theodore E. Ludewick 3617 Lemay Ferry, Lemay	

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy		INTERVAL BETWEEN ONSET AND DEATH 7 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	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 334X	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?

22. I hereby certify that I attended the deceased from Jan 29, 1952 to Feb 6, 1952, that I last saw the deceased alive on Feb 6, 1952, and that death occurred at 7 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Walds Hill - M.D.		23b. ADDRESS 3606 Lemay Ferry Rd. - 8 Mo. 2/6/52		23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 9, 1952	24c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cemetery	24d. LOCATION (City, town, or county) (State) 7030 Gravois, St. Louis, Mo.	

DATE REC'D BY LOCAL REG. 1/17/52	REGISTRAR'S SIGNATURE Herbert K. Poulsen	F. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Hoffmeister U. & St. Co. 7814 So. Broadway, St. Louis, Mo. 11
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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 Harry J. Schumacher

Signed:
Student Embalmer

Licensed Embalmer No. 2679

P. O. Address 7514 1/2 Broadway

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.