

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14217**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3108**

1. PLACE OF DEATH a. COUNTY _____		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) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, 2029	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 4751 Alma	

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM	b. (Middle) _____	c. (Last) DUESING	4. DATE OF DEATH (Month) (Day) (Year) APRIL 1, 1952
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH 2-1-1874	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months _____	IF UNDER 6 HRS. Days _____	IF UNDER 1 HR. Hours _____	Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? Natl.
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13a. FATHER'S NAME Wm. Duesing	13b. MOTHER'S MAIDEN NAME NOT KNOWN	14. NAME OF HUSBAND OR WIFE NONE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. B. Schaper 4751 Alma
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized arteriosclerosis		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
	ANTECEDENT CAUSES DUE TO (b) Malnutrition		
	DUE TO (c) Urethral Strictures and urinary extravasation		
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 _____
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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) (m.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 608X
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22. I hereby certify that I attended the deceased from **2-12-52**, 19____, to **4-1-52**, 19____, that I last saw the deceased alive on **4-1-52**, 19____, and that death occurred at **9:20A m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. Howard Gerry M.D.	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 4-1-52
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24a. BURIAL, CREMATION, OR REMOVAL (Specify) Buried	24b. DATE 4-14-52	24c. NAME OF CEMETERY OR CREMATORY SS. PETER & PAUL	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
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DATE REC'D BY LOCAL REG. APR 2 1952	REGISTRAR'S SIGNATURE J. Carl Smith	GENERAL DIRECTOR'S SIGNATURE ADDRESS Hingermuhle, 3819 S Grand, Mo.
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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.....

George J. McInerney

Licensed Embalmer No. *4611*

Signed.....
Student Embalmer

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.