

STANDARD CERTIFICATE OF DEATH

State File No.

FILED SEP 3- 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7849**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mis souri b. COUNTY 2149	
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	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If rural, give location) 14 5124 Tamm Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Susan b. (Middle) E. c. (Last) Hall		4. DATE OF DEATH (Month) (Day) (Year) Aug. 18 1952	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Dec. 8, 1874
9. AGE (In years last birthday) 77 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY -
11. BIRTHPLACE (State or foreign country) Baltimore County, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Clark	13b. MOTHER'S MAIDEN NAME ? Fowler	14. NAME OF HUSBAND OR WIFE Robert J. Hall
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. -	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Helen Gleave, 5124 Tamm Ave.

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.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 2 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	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 4201

22. I hereby certify that I attended the deceased from **August 16, 1952**, to **August 18, 1952**, that I last saw the deceased alive on **August 17, 1952**, and that death occurred at **3:30 Am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Eugene V. Hunscher M.D.	23b. ADDRESS 6200 Hoffman Ave	23c. DATE SIGNED 8/18/52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Aug. 20, 1952	24c. NAME OF CEMETERY OR CREMATORY Valhalla Chapel of Mem.
24d. LOCATION (City, town, or county) (State) St. Louis County		

DATE REC'D BY LOCAL REG. AUG 19 1952	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Beiderwieden Funeral Home, Inc. 1936 St. Louis
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Eugene V. Henschel,
6200 Hoffman
Sterling 8334
Hours - 1-4

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 _____

Max L. Warfel

Signed _____
Student Embalmer

Licensed Embalmer No. 4170

P. O. Address 1936 St. Louis Av

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.