

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32923

State File No. _____
Registrar's No. 9010

FILED OCT 7 1952

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 MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3140 MAURY		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2167	
3. NAME OF DECEASED (Type or Print) a. (First) CLARA b. (Middle) FAISST c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) SEPT. 26 1952	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH DEC. 13 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	9. AGE (In years last birthday) 64
11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME HENRY L. PETERS		13b. MOTHER'S MAIDEN NAME MARIE KLAUSTERMCIER	
14. NAME OF HUSBAND OR WIFE WILLIAM FAISST		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 WILLIAM FAISST 3140 MAURY	
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) Metastatic Carcinoma of Descending Colon 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 4/10/52		19b. MAJOR FINDINGS OF OPERATION Tumor of descending Colon Obstructed	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.	
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) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 153X	
22. I hereby certify that I attended the deceased from April 7, 1952, to Sept. 26, 1952, that I last saw the deceased alive on Sept. 26, 1952, and that death occurred at 2 P.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) [Signature]		23b. ADDRESS 3606 Harrison	
23c. DATE SIGNED 9/26/52		24a. BURIAL, CREMATION REMOVAL (Specify) REMOVAL	
24b. DATE SEPT. 29 1952		24c. NAME OF CEMETERY OR CREMATORY ST. PAUL CHURCHYARD	
24d. LOCATION (City, town, or county) (State) ST. LOUIS MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutia 2906 Harrison	
DATE REC'D BY LOCAL REG. SEP 29 1952		REGISTRAR'S SIGNATURE [Signature]	

(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.....

Leo J. Budd

Signed.....

Student Embalmer

Licensed Embalmer No.....

3988

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.