

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3222**
Registrar's No. **1175**

No. 200
10.48
681

FILED FEB 11 1953

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

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

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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 5254 Shreve Ave. St. Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 2079 5254 Shreve Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1			

3. NAME OF DECEASED (Type or Print) a. (First) THELMA b. (Middle) c. (Last) HESSION		4. DATE OF DEATH (Month) (Day) (Year) Feb. 1, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, married (Specify)	8. DATE OF BIRTH 10-19-16
9. AGE (In years last birthday) 36		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Missouri
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Own home	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Charles Dunn	13b. MOTHER'S MAIDEN NAME Elsie Hardwick	14. NAME OF HUSBAND OR WIFE Buster W. Hession
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes	16. SOCIAL SECURITY NO. W.W. #2 unknown	17. INFORMANT'S SIGNATURE OR NAME Buster W. Hession	ADDRESS St. Louis, Mo.
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 24 HRS.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Infarction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Thrombophlebitis in Legs DUE TO (c) Rheumatic Heart Disease		25 YRS.
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"/>
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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)
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? 41 Car

22. I hereby certify that I attended the deceased from **Jan. 3, 1953**, to **Feb. 1, 1953**, that I last saw the deceased alive on **2-3, 1953**, and that death occurred at **8:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Rob R. Branch M.D.	23b. ADDRESS 1515 Lafayette Ave.	23c. DATE SIGNED 2-1-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-1-53	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Belleville, Ill.
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DATE REC'D BY LOCAL REG. FEB 2 1953	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. POWER OF ATTORNEY'S SIGNATURE C. L. Lander	ADDRESS Belleville, Ill.
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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. _____

Student
Student Embalmer r

Body not embalmed
Signed *W. Gardner* _____

Licensed Embalmer No. _____

P. O. Address _____

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.