

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11740

State File No.

FILED APR 4 1953

318

1003

Registrar's No. 2907

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY _____ 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) St Louis c. LENGTH OF STAY (in this place) 2 days c. CITY (If outside corporate limits, write RURAL and give township) St Louis 2159

d. FULL NAME OF HOSPITAL OR INSTITUTION St Anthony Hospital d. STREET ADDRESS (If rural, give location) 15 5146 Cologne 0

3. NAME OF DECEASED a. (First) Rosa b. (Middle) Elizabeth c. (Last) Huber 4. DATE OF DEATH (Month) (Day) (Year) Mar. 16, 1953

5. SEX female 6. COLOR OR RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 8. DATE OF BIRTH May 18, 1884 9. AGE (In years last birthday) 68 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) housewife 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) Switzerland 5 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME not known 13b. MOTHER'S MAIDEN NAME not known 14. NAME OF HUSBAND OR WIFE Gustave Huber

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. none 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Gustave Huber 5146 Cologne

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy short
ANTECEDENT CAUSES DUE TO (b) Malignant Hypertension 2 days
DUE TO (c) several years
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 OPERATIONS Cerebral Hemorrhage 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 3:31 AM

22. I hereby certify that I attended the deceased from March 10, 1953 to March 16, 1953, that I last saw the deceased alive on March 16, 1953 and that death occurred at 3:30A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. Carl Smith, M.D. 23b. ADDRESS 3606 Harris 23c. DATE SIGNED 3/17/53

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 3/18/53 24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park 24d. LOCATION (City, town, or county) (State) Affton Mo.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. Carl Smith, M.D. 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J L Ziegenhein & Sons 7027 Gravois

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

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

E. P. Kudwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gravois

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.