

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

11983

FILED MAR 31 1953

State File No.

318

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|---|--|---|--|--|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. _____ | | Registrar's No. _____ | |
| 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. LENGTH OF STAY (In this place) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis | | 2239 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital | | | | d. STREET ADDRESS (If rural, give location) 23 1033 Lami Street | | | |
| 3. NAME OF DECEASED (Type or Print) AUGUSTA | | a. (First) | | b. (Middle) | | c. (Last) MARTY | |
| 4. DATE OF DEATH MARCH 9, 1953 | | 4. DATE OF DEATH (Month) (Day) (Year) | | 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3 | | 8. DATE OF BIRTH June 21 1882 | | 9. AGE (In years last birthday) 70 | | 10. # UNDER 1 YEAR Days | |
| 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 (City and State or Foreign Country) St Genevieve Mo | | 12. CITIZEN OF WHAT COUNTRY? U S | |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE | | | |
| 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 Frank Marty R R 1 Arnold Mo. | | | |
| 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) <u>Cerebral vascular accident</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive cardio-vascular disease</u> DUE TO (c) <u>and Arteriosclerotic heart disease</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND 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) | | 21f. HOW DID INJURY OCCUR? 4200 | |
| 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"/> | | 22. I hereby certify that I attended the deceased from 3-2-53, 19, to 3-9-53, 19, that I last saw the deceased alive on 3-9-53, 19, and that death occurred at 5:35A m., from the causes and on the date stated above. | | | |
| 23a. SIGNATURE James B. Stuchan, Jr. M.D. | | (Degree or title) | | 23b. ADDRESS 1515 Lafayette Avenue | | 23c. DATE SIGNED 3-9-53 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 3/11/53 | | 24c. NAME OF CEMETERY OR CREMATORY Nrw St Marcus Cemetery | | 24d. LOCATION (City, town, or county) (State) St Louis Mo. | |
| DATE REC'D BY LOCAL MAR 10 1953 | | REGISTRAR'S SIGNATURE J. Carl Smith, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Moydell Funeral Home 1926 Allen Av | | | |

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Paul A. [Signature]*

Licensed Embalmer No. 4533

P. O. Address *[Signature]*

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.