

FILED APR 4 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12447  
Registrar's No. 3176

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,		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, 2269	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3703a North 20th. Street		d. STREET ADDRESS (If rural, give location) 26 3703a North 20th. Street	

3. NAME OF DECEASED (Type or Print) a. (First) Augusta	b. (Middle)	c. (Last) Uhlich	4. DATE OF DEATH (Month) (Day) (Year) March 23 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 18 1868	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Frederich Schwartz	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE Ferdinand Uhlich
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Dont know
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Valvular Heart Disease		
	ANTECEDENT CAUSES Asford 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"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) NO	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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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"/>	21f. HOW DID INJURY OCCUR 4214
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22. I hereby certify that I attended the deceased from Oct. 1848, to Mar. 23 1953 that I last saw the deceased alive on Mar. 23, 1953 and that death occurred at 1:50 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) A. D. Minneman M.D.	23b. ADDRESS 5320 Geraldine	23c. DATE SIGNED 3-24-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-28-1953	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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DATE REC'D BY LOCAL REG. MAR 24 1953	REGISTRAR'S SIGNATURE J. C. Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Beiderwieden F.H. Inc. 1936 St. Louis Ave.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. R. R. Menown  
5330 Geraldine  
Hours-11to1 and 6to7

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 Helis J. Krushin

Licensed Embalmer No. 3497

P. O. Address St Louis

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.