

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12450

State File No. 12450

FILED MAR 18 1953

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2043

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 OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2019	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital				d. STREET ADDRESS (If rural, give location) 310 Dover Street			
3. NAME OF DECEASED (Type or Print) AUGUSTA		a. (First)		b. (Middle) ****		c. (Last) UTHOFF	
4. DATE OF DEATH Feb. 21, 1953		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Aug. 21, 1870		9. AGE (In years last birthday) Months Days Hours Min. 82	
5. SEX Female		6. COLOR OR RACE White		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	
11. BIRTHPLACE (City and State or Foreign Country) Illinois		12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME (Unk.) Kolb		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE John H. Uthoff		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 Ruth Uthoff 310 Dover St. Louis 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) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive arteriosclerosis, 10 yrs DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Sanity				INTERVAL BETWEEN ONSET AND DEATH 3 wks	
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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 332X		22. I hereby certify that I attended the deceased from May, 1947 , to Feb. 21, 1953 , that I last saw the deceased alive on Feb. 21, 1953 and that death occurred at 7 P. M. , from the causes and on the date stated above.			
23a. SIGNATURE Burchard W. Smith MD		(Degree or title)		23b. ADDRESS 6006 Virginia		23c. DATE SIGNED 2-23-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Feb. 24, 1953		24c. NAME OF CEMETERY OR CREMATORY New St. Marcus		24d. LOCATION (City, town, or county) (State) 79011 Gravois	
DATE REC'D BY LOCAL REG. FEB 24 1953		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE C. Hoffmeister U. & L. Co		ADDRESS 7817 So. Broadway St. Louis Mo.	

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

11-17-20

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

Harry J. Schumaker

Licensed Embalmer No. 2679

P. O. Address 7814 S. Broadway

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.