

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 26 1953

State File No.

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 5660

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St. Louis, Mo.</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Webster Groves, Mo. 4587</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. John Hospital</i>		d. STREET ADDRESS (If rural, give location) <i>520 Lake Ave. 1</i>	

3. NAME OF DECEASED (Type or Print) a. (First) <i>EMMA</i> b. (Middle) <i>W.</i> c. (Last) <i>LEUTHEUSSER</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>June 5, 1953</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>June 16, 1870</i>
9. AGE (In years last birthday) <i>82</i>		10. AGE (In years last birthday) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (City and State or Foreign Country) <i>St. Louis, Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	

13a. FATHER'S NAME <i>BALTHASER WEBER</i>	13b. MOTHER'S MAIDEN NAME <i>MARIE MEIER</i>	14. NAME OF HUSBAND OR WIFE <i>ARTHUR O. LEUTHEUSSER</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <i>Arthur O. Leutheusser, Webster Groves, Mo. 520 Lake Ave.</i>

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	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Rheumatic Valvular Aortic & Mitral</i>		with subacute bacteriemia		<i>5 weeks</i>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <i>carditis</i>			
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Terminal acute glomerular nephritis</i>		<i>1 week</i>	
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) <i>No</i>	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? <i>410X</i>

22. I hereby certify that I attended the deceased from *5-26*, 19*53*, to *6-5*, 19*53*, that I last saw the deceased alive on _____, 19____, and that death occurred at *12:30 Pm.*, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>John F. Hammond M.D.</i>	23b. ADDRESS <i>634 N. Grand</i>	23c. DATE SIGNED <i>6/5/53</i>
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	24b. DATE <i>June 8, 1953</i>	24c. NAME OF CEMETERY OR CREMATORY <i>New Bethlehem Cemetery</i>
24d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo.</i>		

DATE REC'D BY LOCAL REG. <i>JUN 8 1953</i>	REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <i>Reiderwieden F.H. Inc., 1936 St. Louis Ave</i>
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. John Hammon & Dr. John King
Mo. Theatre Bldg

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 _____

Licensed Embalmer No. 349

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.