

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

26496

1003

State File No.

318

6866

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 <u>Missouri</u>				b. COUNTY <u>St. Louis</u>			
b. CITY OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>6 hrs.</u>		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Marian Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>16 3151a Cherokee St., St. Louis 18</u>							
3. NAME OF DECEASED (Type or Print) <u>Elsie Hosch</u>			a. (First)		b. (Middle)		c. (Last)				
4. DATE OF DEATH <u>July 11, 1953</u>			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <u>Never married</u>		8. DATE OF BIRTH <u>JUNE 27, 1889</u>		9. AGE (In years last birthday) <u>64</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13a. FATHER'S NAME <u>Augusta Frederick Hosch</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Jane Walters</u>			14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>489-12-2615</u>			17. INFORMANT'S SIGNATURE OR NAME <u>Alfred H. Hosch, 3151a Cherokee St., 18,</u>			ADDRESS _____		
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, asthma, etc. It means the disease, injury, or complication which caused death.				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Embolism</u>				INTERVAL BETWEEN ONSET AND DEATH <u>several days</u>			
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Mitral Valvular Heart Disease</u>							
				DUE TO (c) _____							
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>							
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? <u>410X</u>							
22. I hereby certify that I attended the deceased from <u>May 29, 1953</u> to <u>July 11, 1953</u> , that I last saw the deceased alive on <u>July 10, 1953</u> , and that death occurred at <u>12:30 p. m.</u> , from the causes and on the date stated above.											
23a. SIGNATURE <u>[Signature]</u>						23b. ADDRESS <u>3612 S. Jefferson</u>			23c. DATE SIGNED <u>July 12, 1953</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 13, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Cemetery</u>		24d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>		(State) _____			
DATE REC'D. BY LOCAL REG. <u>JUL 13 1953</u>			REGISTRAR'S SIGNATURE <u>[Signature]</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>			ADDRESS <u>6464 Chippewa St., St. Louis, Missouri</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10. FILED

JUL 31 1953

Dr. Lewis Resnikoff,
3612 S. Jefferson,
Sidney 2479

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.....
Signature of Student Embalmer

Signed..... *Harry J. Schumacher*
Licensed Embalmer No. *2679*
P. O. Address *7819 S. Broad*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.