

No. 300  
10-48

FILED OCT 27 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34631**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **2406**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>2179</b>	
b. CITY OR TOWN <b>Carsonville</b>	c. LENGTH OF STAY (in this place) <b>7 Years</b>	c. CITY OR TOWN <b>St. Louis</b>	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 <b>Penn Nursing Home</b>		e. STREET ADDRESS (If rural, give location) <b>3864 Shenandoah Ave</b>	

<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>James</b> b. (Middle) _____ c. (Last) <b>Huskey</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Sept 9 1953</b>		
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<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>May 22 1874</b>		<b>9. AGE</b> (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Factory worker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>International Shoe Co</b>		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Desoto Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
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<b>13a. FATHER'S NAME</b> <b>Peter Huskey</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary Wideman</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Dec. Elizabeth, Wilson, Huskey.</b>	
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>492-01-7463</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Jack Huskey</b>				<b>ADDRESS</b> <b>3864 Shenandoah Ave</b>	
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<b>18. CAUSE OF DEATH</b> 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.	<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Arteriosclerotic Cardiovascular disease</b>					<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____ <b>disease</b>					<b>unknown</b>	
	DUE TO (c) _____ <b>Old left hemiplegia</b>					<b>5 years.</b>	
	<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.						

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>					<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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<b>21a. ACCIDENT, SUICIDE, HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP)</b> <b>4221</b>		<b>(COUNTY)</b>		<b>(STATE)</b>	
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>					
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**22. I hereby certify that I attended the deceased from Oct 19, 1952, to Sept 9, 1953, that I last saw the deceased alive on Sept 8, 1953, and that death occurred at 11:30 P.M. from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <b>Lewis Litzman M.D.</b> (Degree or title)		<b>23b. ADDRESS</b> <b>8231 Clayton Rd.</b>		<b>23c. DATE SIGNED</b>	
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>24b. DATE</b> <b>Sept 12 1953</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Sunset Burial Park</b>		<b>24d. LOCATION</b> (City, town, or county) (State) <b>St. Louis County Mo.</b>			
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<b>DATE REC'D BY LOCAL REG.</b> <b>9/10/53</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Wesley B. Jenke M.D.</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Weick Bros</b>					<b>ADDRESS</b> <b>2201 S. Grand Blvd</b>	
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(Licensed Embalmer's Statement on Reverse Side)

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

DR. LEWIS H. LITMAN

8231 Clayton Rd.

Pa 0202

3. to 5 Thur.

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..... *[Handwritten Signature]*

Licensed Embalmer No. 45

P. O. Address..... *[Handwritten Address]*

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.