

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41319

State File No. ....

FILED NOV 27 1953

318

1003

10896

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST Louis		2079	
d. FULL NAME OF HOSPITAL OR INSTITUTION Hqob W. Florissant				d. STREET ADDRESS (If rural, give location) 7 4906 W. Florissant			
3. NAME OF DECEASED (Type or Print) MARGARET			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 11-16-53	
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH 8-14-1861	
9. AGE (In years last birthday) 92		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) A.T. HOME		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (City and State or Foreign Country) HOLLAND	
13a. FATHER'S NAME Herman Jobusch		13b. MOTHER'S MAIDEN NAME BARBARA Herman		14. NAME OF HUSBAND OR WIFE August Voss			
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 Mrs. W. A. Soedeker, Florissant			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. PRECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____					
		III. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture of right hip.					
19a. DATE OF OPERATION 9-11-53		19b. MAJOR FINDINGS OF OPERATION Fractured hip				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, factory, store, office bldg., etc.) Home		21c. (CITY, TOWN) OR TOWNSHIP (COUNTY) (STATE) St. Louis Mo.			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9 7 52 AM		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fall at home		4500f	
22. I hereby certify that I attended the deceased from 9/7, 1953, to 11/16, 1953, that I last saw the deceased alive on 11/14, 1953, and that death occurred at 10:45 AM., from the causes and on the date stated above.							
23a. SIGNATURE H. F. Bergman				23b. ADDRESS M.D. 9 3720 Washington		23c. DATE SIGNED 11/16/53	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 11-18-53		24c. NAME OF CEMETERY OR CREMATORY Bellfontaine		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. NOV 17 1953		REGISTRAR'S SIGNATURE C. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE A. Now		ADDRESS 414 N. Grand	

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

**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 Ronald O. Mahan

Licensed Embalmer No. 3197

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.