

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31726

FILED SEP 21 1954

State File No.

BIRTH NO. _____ REG. DIST. NO. **818** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8169**

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 MO	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN ST. LOUIS	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 2340 S. 12th ST.		e. STREET ADDRESS (If rural, give location) 23 2340 S. 12th ST.	

3. NAME OF DECEASED (Type or Print)	a. (First) FLORENCE M.	b. (Middle)	c. (Last) DECKERT	4. DATE OF DEATH (Month) (Day) (Year) SEPT 3 1954
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JULY 4 1887	9. AGE (In years last birthday) 67	UNDER 1 YEAR Months	IF UNDER 1 Hrs. Hours	Min.
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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) NEBRASKA	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME JOHN WUESET	13b. MOTHER'S MAIDEN NAME BARBARA KELNER	14. NAME OF HUSBAND OR WIFE THEODORE DECKERT
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME THEODORE DECKERT	ADDRESS 2340 S. 12th
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Progressive Glossio-Labio-Laryngeal Paralysis		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
	ANTECEDENT CAUSES DUE TO (b) Cerebral Hemiplegia		
	DUE TO (c) Arterio-Sclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			6 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 334x

22. I hereby certify that I attended the deceased from **Dec. 9, 1948** to **Sept. 3, 1954**, that I last saw the deceased alive on **Sept. 3, 1954**, and that death occurred at **6:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or Title) Robert F. Henke MD	23b. ADDRESS 3109 S. Grand Blvd.,	23c. DATE SIGNED 9/3/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE SEPT 7 1954	24c. NAME OF CEMETERY OR CREMATORY RESURRECTION	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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DATE REC'D BY LOCAL REG. SEP 7 1954	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kuter	ADDRESS 2906 Leavis
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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.....
Signature of Student Embalmer

Signed..... *James E. Hill*

Licensed Embalmer No. *434*

P. O. Address *2906 St.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fails 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.