

FILED DEC 17 1954

STANDARD CERTIFICATE OF DEATH

State File No. **42146**

BIRTH NO. _____

REG. DIST. NO. **318**PRIMARY REG. DIST. NO. **1003**Registrar's No. **10994**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		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 3526a Humphrey St.			STREET ADDRESS (If rural, give location) 16 3526a Humphrey St. 2169		
3. NAME OF DECEASED (Type or Print) ROSE		a. (First)	b. (Middle) AGNES	c. (Last) ARMBRUSTER	4. DATE OF DEATH (Month) (Day) (Year) Nov. 30 1954
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Feb. 7, 1870	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Binder (Retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William Armbruster		13b. MOTHER'S MAIDEN NAME Anna Fasshauer		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Barbara Armbruster 3526a Humphrey St.			
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) Cerebral apoplexy	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. arteria sclerosis myo corditis chronic	DUE TO (b)	DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 6 days 5 yr 6 yr
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION none				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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? 4221			
22. I hereby certify that I attended the deceased from 11:30 , 19 54 , to Nov 30 , 19 54 , that I last saw the deceased alive on 11:30 , 19 54 , and that death occurred at 3:45 P m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Madison Gleason M.D.			23b. ADDRESS 506 Olive St.		23c. DATE SIGNED 12/1/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 3, 1954	24c. NAME OF CEMETERY OR CREMATORY S/S Peter & Paul Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
DATE REC'D BY LOCAL REG. DEC 2 1954	REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.		

(Licensed Embalmer's Statement on Reverse Side)

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 *Paul A. Johnson*.....
Licensed Embalmer No. *453*.....

P. O. 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.

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