

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18833

STATE FILE NUMBER  
**5291**

FILED JUN 14 1957

Registration District No. **318** Primary Registration District No. **1003**

Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence/before admission) a. STATE <b>Mo.</b> b. COUNTY <b>1</b>  c. CITY OR TOWN <b>2119 SPRUCE</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET <b>2119 SPRUCE</b> (If outside, give location) ADDRESS Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP.</b> Length of stay in lb <b>#1.</b>		d. STREET ADDRESS <b>2119 SPRUCE</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>GUS</b> Middle _____ Last <b>HOUSE</b>		<b>4. DATE OF DEATH</b> Month <b>MAY</b> Day <b>18</b> Year <b>1957</b>	
<b>5. SEX</b> MALE <b>2</b>	<b>6. COLOR OR RACE</b> NEGRO	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> AUG. 4, 1881
<b>9. AGE</b> (In years last birthday) <b>75</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> UNKNOWN	<b>11. BIRTHPLACE</b> (City and state or country) MISS /
<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.		<b>13. FATHER'S NAME</b> WILFORD	
<b>14. MOTHER'S MAIDEN NAME</b> TILDA		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service)	
UNKNOWN		<b>16. SOCIAL SECURITY NO.</b> UNKNOWN	
<b>17. INFORMANT</b> (Address) <b>ST. LOUIS CITY HOSP. #1.</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic pyelonephritis</b>		DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <b>Arteriosclerotic heart disease</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>	
<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (e. g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21. I attended the deceased from</b> <b>4/26/57</b> to <b>5/18/57</b> and last saw her alive on <b>5/18/57</b> Death occurred at <b>3:55 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		<b>22a. SIGNATURE</b> (Degree or title) <b>Stephen A. Birch</b> <b>0.</b>	
<b>22b. ADDRESS</b> <b>1515 LAFAYETTE AVE.</b>		<b>22c. DATE SIGNED</b> <b>5/20/57</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>6-29-57</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Anatomical Board</b>	
<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis, Mo.</b>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Rowland-Aker Mortuary Service</b> <b>4104 Manchester Ave.</b> <b>St. Louis 10, Mo.</b>	
<b>25. DATE RECD. BY LOCAL REG.</b> <b>JUN 6 '57</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Carl Smith Mo</b> <b>mjs</b>	

health, Welfare Public Service  
 300 1-56  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ..... Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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