

health, Welfare public service  
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 All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 every person, etc. - West case - only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

FILED MAY 27 1957

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

19237

318

1003

STATE FILE NUMBER 4753

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>04 BARNES HOSPITAL</b>			Length of stay in 1b <b>2 1/2</b>	d. STREET ADDRESS (If outside, give location) <b>4419 Arco Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>M. WEBER</b> Last <b>- RUESSING</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>19</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1875</b>	9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Switzerland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Kaiser</b>			14. MOTHER'S MAIDEN NAME <b>Mary Graf</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>489-14-6191</b> <b>495-28-8955</b>	17. INFORMANT Address (Husband) <b>John Rueessing 4419 Arco Ave.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>331x</b>  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease &amp; Congestive Heart Failure</b>					INTERVAL BETWEEN ONSET AND DEATH  <b>Sev Yrs.</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour: _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from <b>MAY 15, 1957</b> to <b>MAY 19, 1957</b> and last saw her alive on <b>MAY 15, 1957</b> Death occurred at <b>8:12 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>C. J. Vermillion, M.D.</b>			22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>5/19/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>May 22, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Missouri Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 4228 S. Kingshighway</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 20 '57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		

(Licensed Embalmer's Statement on Reverse Side)

8701

8701

STATEMENT BY LICENSED EMBALMER

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2781

1916-11-28  
1920-02-20

**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 *Edwin A. Mc Dermott*

Licensed Embalmer No. *302*

P. O. Address .....

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