

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 20 1957

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1242

Health, Welfare, Public, Service
000
1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>									
-- b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Affton St. George</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>St. George 4820</u> <u>Affton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>9824 Zenith Dr.</u>			Length of stay in 1b <u>9 Yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>9824 Zenith Dr.</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>I.</u> Last <u>HUGHART</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1957</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 20, 1885</u>		9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 26 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse-Public Health</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dep't.-State of</u>		11. BIRTHPLACE (City and state or country) <u>Ohio Millboro Springs, Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Hughart</u>						14. MOTHER'S MAIDEN NAME <u>Dora McGuffin</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hester Mueller</u> Address <u>9824 Zenith Dr.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Plu Arterio Sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____										INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>3 years</u>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No</u>										
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____										
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION _____			COUNTY _____			STATE _____				
21. I attended the deceased from <u>Jun 1956</u> to <u>5-13-57</u> and last saw her alive on <u>5-13-57</u> Death occurred at <u>8:00 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>W W. Torman MD</u>						22b. ADDRESS <u>9505 Gravois</u>				22c. DATE SIGNED <u>5-14-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>May 16, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>				
24. FUNERAL DIRECTOR <u>Kriegshauser</u> ADDRESS <u>4228 S. Kingshighway</u>					25. DATE RECD. BY LOCAL REG. <u>5-14-57</u>			26. REGISTRAR'S SIGNATURE <u>Herbert A. Deane MD</u>					

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 *Richard W. Storvick*

Licensed Embalmer No. *49*

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.