

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-011727  
STATE FILE NUMBER  
2454

FILED MAR 19 1958

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2454**

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-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hosp.</b>		Length of stay in lb. <b>25</b>	STREET ADDRESS (If outside, give location) <b>6241 Alexander Drive</b>

3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Charles</b> Last <b>Hausman.</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>27</b> Year <b>1958</b>	
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5. SEX <b>Male</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>April 25, 1873</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>2</b>	IF UNDER 24 HRS. Hours <b>2</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Candy Bus.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Albert Hausman.</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Meyer</b>	14. NAME OF HUSBAND OR WIFE <b>Donna Wells Hausman</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Donna Wells Hausman</b> Address <b>6241 Alexander Dr.</b>
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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 Arteriosclerosis</b> <b>General Arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>334X</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		

20d. INJURY OCCURRED WHILE AT <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 _____
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21. I attended the deceased from **Jan. 2, 1958** to **Feb. 27, 1958** and last saw her alive on **Feb. 27, 1958**  
Death occurred at **2115** p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Miriam. Hyslop M.D.</b>	22b. ADDRESS <b>3720 Washy Rd</b>	22c. DATE SIGNED <b>2/28/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>3 / 1 / 58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
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24. FUNERAL DIRECTOR <b>E. R. Lupton &amp; Sons 7233 Delmar Blvd.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>FEB 28 '58</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in referring to the cause of death. All diseases in Part I must be causally related.

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*.....  
P. O. Address *St. Louis, Mo.*

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.