Health, Welfare Public Service

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FILED APR 3 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-011957
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3568

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐

c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis City Hospital #1 — Length of stay in 1b 25

d. STREET ADDRESS (If outside, give location) 5150 Dresden Ave. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Jacob Middle M. Last Ludwig

4. DATE OF DEATH Month March Day 26 Year 1958

5. SEX Male 0

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH July 23, 1877

9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired machinist

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Jacob Ludwig

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Elizabeth Ludwig

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Elizabeth Ludwig Address 5150 Dresden Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriolar Nephrosclerosis — 5 Yrs
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Multiple Emboli from Mural Thrombi 4201

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 Mar. 13, 1958, to Mar. 26, 1958 and last saw her/him alive on Mar. 26, 1958
Death occurred at 2:10 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John W. Strzich M.D. 0

22b. ADDRESS 1515 Lafayette

22c. DATE SIGNED 3/26/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE MARCH 29 1958

23c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul

23d. LOCATION (City, town, or county) (State) St. Louis Mo

24. FUNERAL DIRECTOR Thos. Kutis ADDRESS 2906 Gravois

25. DATE RECD. BY LOCAL REG. MAR 28 '58

26. REGISTRAR'S SIGNATURE J Carl Smith MD MDB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 Leo J. Budde

Licensed Embalmer No. 3989

P. O. Address 2906 [illegible]

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.