

Health, Welfare, Public Service, 300, 1-56, All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, Coroner, etc. must use only standard nomenclature in their reports. Symptoms must be listed. Cause of death must be stated. Coroner cannot certify to a death due to natural causes. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015695  
STATE FILE NUMBER

FILED APR 28 1958

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3705**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <b>St. Louis</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				a. STATE <b>Mo.</b>		b. COUNTY <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>32 St. Lukes Hosp.</b> Length of stay in 1b <b>4 days</b>				c. CITY OR TOWN <b>Webster Groves</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RUTH SALVETER CUSHING</b>				4. DATE OF DEATH <b>Apr. 1, 1958</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</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>Apr. 10, 1896</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		9. AGE (In years last birthday) <b>61</b>	
11. BIRTHPLACE (City and state or country) <b>Webster Groves, Mo.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Henry C. Salveter</b>				14. MOTHER'S MAIDEN NAME <b>Cora Van Amburgh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edward F. Cushing</b> Address <b>29 N. Maple</b>	
18. CAUSE OF DEATH [Enter only one cause per line in (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatoid Arthritis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>722.0</b> DUE TO (c) _____ 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 <b>20 years</b>	
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 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>1946</b> to <b>4/1/58</b> and last saw <sup>her</sup> him alive on <b>4/1/58</b> Death occurred at <b>11:30 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Paul O. Hagemann M.D.</b> (Degree or title)				22b. ADDRESS <b>3720 Washington</b>		22c. DATE SIGNED <b>4/2/58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>4-2-58</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 <b>Parker-Aldrich</b> ADDRESS <b>Webster Groves</b>				25. DATE RECD. BY LOCAL REG. <b>APR 2 '58</b>		26. REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>	

(Licensed Embalmer's Statement on Reverse Side)

*m. J. B.*

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 embalmed by me, or by No embalming, Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Leslie Welch.....

Licensed Embalmer No. 43

P. O. Address Wester

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.