

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019769

STATE FILE NUMBER

FILED MAY 23 1958

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5140**

300  
1-57

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. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer Phillips Hosp.</b>			Length of stay in lb <b>45 Min.</b>	d. STREET ADDRESS (If outside, give location) <b>4510a Athlone Avenue</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle Last <b>HAUSER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 10, 1883</b>		9. AGE (In years last birthday) <b>75</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>Foreman - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mallinckrodt Chem.</b>		11. BIRTHPLACE (City and state or country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Franz X. Hauser</b>			13b. MOTHER'S MAIDEN NAME <b>Marie Merkt</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</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>488-09-7389</b>		17. INFORMANT Address <b>Mr. Berthold Winker - 5935 Drury Lane</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>Fracture of Skull;</b> DUE TO (b) <b>Subdural Hemorrhage of Brain</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) <b>Suffered when deceased fell down steps in front of his house on May 3rd 1958 about 10:15 p.m.</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. OTHER BE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) <b>fell down steps in front of his house on May 3rd 1958 about 10:15 p.m.</b>					
20c. TIME OF INJURY <b>10:15 p.m. - 5 1958</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b>9 Home</b>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, store, office bldg., etc.) <b>9 Home</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo.</b>				COUNTY STATE	
21. I attended the deceased from <b>12 MIDNITE</b> to <b>3</b> and last saw her/him alive on <b>5/15/58</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deputy or title) <b>Jay M. Quinn State 3</b>				22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>5/15/58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 16, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Math Hermann &amp; Son, Inc., 2161 E. Fair</b>				25. DATE RECD. BY LOCAL REG. <b>MAY 15 '58</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> <b>S.P.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 Wesford G. Burnley

Licensed Embalmer No. 4203

P. O. Address Albany, N.Y.

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.