Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-030538
STATE FILE NUMBER

FILED AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7518

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: 67 Christian Hospital — Length of stay in Hospital: 17 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Gasconade
c. CITY OR TOWN: 037 0 Red Bud — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 31 — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Susan Middle: Ann Last: Holt

4. DATE OF DEATH: Month: July Day: 31 Year: 1958

5. SEX: Female 1
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH: May 19, 1867
9. AGE (In years last birthday): 91 — 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): Housework
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Gasconade Co., Mo. 0
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: Christian Embe
13b. MOTHER'S MAIDEN NAME: Sarah Garrison
14. NAME OF HUSBAND OR WIFE: George B. Holt

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.: None
17. INFORMANT: Ray Holt, Address: 5321 Cabanne Ave.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 27 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic cerebro vascular disease — several years
DUE TO (c) 332X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arteriosclerotic Heart disease

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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 November 1957, to July 31, 1958 and last saw her alive on July 30, 1958.
Death occurred at 3:30 am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Sylvester A. Flotte (Degree or title) M.D. 0
22b. ADDRESS: 8700 Riverview Blvd
22c. DATE SIGNED: 8-1-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 7-31-58
23c. NAME OF CEMETERY OR CREMATORY: New Salem Cemetery
23d. LOCATION (City, town, or county) (State): Owensville, Mo.

24. FUNERAL DIRECTOR: Albert H. Hoppe, ADDRESS: 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: AUG 1 '58
26. REGISTRAR'S SIGNATURE: J. Earl Smith M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

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 John S. Deimeke

Licensed Embalmer No. 4109

P. O. Address St. Louis,

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.