

t. Health,
& Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034349
STATE FILE NUMBER

FILED OCT 3 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9228

S. 300
v. 1-57

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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4338 Linton Ave		Length of stay in lb 2099	d. STREET ADDRESS (If outside, give location) 4338 Linton Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Clara Loretta Huddleston			4. DATE OF DEATH Month Day Year Sept. 24. 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3. 1895	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days 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) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Henry Kulage		13b. MOTHER'S MAIDEN NAME Elizabeth Hennick		14. NAME OF HUSBAND OR WIFE James F. Huddleston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, <u>Not known</u>) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Address James F. Huddleston 4338 Linton Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Combined Sclerosis Disease</u> DUE TO (b) <u>Malnutrition etc.</u> DUE TO (c) <u>345X</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>
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? 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 <input type="checkbox"/> WORK 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 <u>1955</u> to <u>Sept 19</u> and last saw <u>her</u> alive on <u>Sept 19</u> Death occurred at <u>11:45</u> p m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Johna. Hartwig M.D.</u>			22b. ADDRESS <u>2807 N. Grand Blvd.</u>		22c. DATE SIGNED (State) <u>9/24/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/26/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u>		23d. LOCATION (City, town, or county) <u>St. Louis, Mo</u>
24. FUNERAL DIRECTOR Stock Mortuary 2117 E. Grand			25. DATE RECD. BY LOCAL REG. <u>SEP 25 '58</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u> MFB

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. Inquired: How started? Who is like multiple sclerosis
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr. John A. Hartwig.

2807 N. Grand

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 *Paul A. Wachtel*

Licensed Embalmer No. *04787*

P. O. Address... *Ham 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.