

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038012
STATE FILE NUMBER
REGISTRAR'S NO. 9769

FILED OCT 23 1958 Registration District No. 318 Primary Registration District No. 1003

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		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3856 FAIRVIEW		d. STREET ADDRESS (If outside, give location) 3856 FAIRVIEW	
3. NAME OF DECEASED (Type or print) First Middle Last AUGUSTA A MAUL		4. DATE OF DEATH Month Day Year OCT 10 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 FEB 23 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	12. CITIZEN OF WHAT COUNTRY? U-S-A
13a. FATHER'S NAME JOSEPH RUCKENBROD		13b. MOTHER'S MAIDEN NAME AMELIA ROTH	14. NAME OF HUSBAND OR WIFE GEORGE MAUL
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address GEORGE MAUL 3856 FAIRVIEW
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 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis			5 yrs
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) Arteriosclerosis hemiparesis + Parkinsonism			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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Jan 23, 1957 to Oct 10, 1958 and last saw her ^{him} alive on Oct 9/1958 Death occurred at 3:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Edward W. Czerninski MD		22b. ADDRESS 3701 E. randel Sq	
22c. DATE SIGNED 10/11/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE OCT 13 1958	23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK	23d. LOCATION (City, town, or country) (State) ST. LOUIS MO
24. FUNERAL DIRECTOR ADDRESS Thomas Kutis 2906 Gravois		25. DATE RECD. BY LOCAL REG. OCT 14 '58	26. REGISTRAR'S SIGNATURE Carl Smith MD

300
1-57

All diseases in Part I must be causally related. NO symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1-402m
J.S.
3.4430

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 *Samuel O. Dill*

Licensed Embalmer No. *4347*
P. O. Address *2906 ...*

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.