

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041495

STATE FILE NUMBER

FILED DEC 5 1958

Registration District No.

318

Primary Registration District No.

1003

Registration No.

11251

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS			
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 BRIDGETON 4000	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 3718 MIDVIEW		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 23 BT. JOHNS HOSP		Length of stay in lb 2 WKS		d. STREET ADDRESS (If outside, give location) 27 3718 MIDVIEW	
3. NAME OF DECEASED (Type or print) First Middle Last HILDA C. DUISEN			4. DATE OF DEATH Month Day Year NOV. 21 1958		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 3 1893	9. AGE (In years last birthday) 65	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) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME GUSTAV RISCHECK		13b. MOTHER'S MAIDEN NAME MARTHA VORTISH		14. NAME OF HUSBAND OR WIFE JOSEPH L. DUISEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or, or unknown) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO. 493 24 4866	17. INFORMANT Address JOSEPH L. DUISEN 3718 MIDVIEW		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rheumatic heart disease with aortic stenosis</i> DUE TO (b) <i>Acute congestive heart failure</i> DUE TO (c) <i>Terminal broncho pneumonia</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) <i>411 X</i>					INTERVAL BETWEEN ONSET AND DEATH <i>many years?</i> <i>20 hrs.</i> <i>12 hrs.</i>
20a. ACCIDENT SUICIDE HOMICIDE <i>No No No</i>		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 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 <i>11-1-58</i> to <i>11-21-58</i> and last saw her alive on <i>11-21-58</i> Death occurred at <i>4 pm</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>John J. Hammond M.D.</i>			22b. ADDRESS <i>634 N. Grand</i>		22c. DATE SIGNED <i>11/22/58</i>
23a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>11-24-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>OAK GROVE CEMETERY</i>		23d. LOCATION (City, town, or county) (State) <i>ST LOUIS COUNTY MO</i>	
24. FUNERAL DIRECTOR ADDRESS <i>COLLIER MORTUARY ST. ANN MO.</i>			25. DATE RECD. BY LOCAL REG. <i>NOV 22 58</i>	26. REGISTRAR'S SIGNATURE <i>John Paul Smith, M.D.</i> <i>J.P.</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Sheldon Collier*

Licensed Embalmer No. *3388*

P. O. Address *A. M. G.*

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.