

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041671

STATE FILE NUMBER

FILED NOV 20 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10829

300
-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. 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 01 1303 Warren St.		Length of stay in lb 20 Yrs	d. STREET ADDRESS 2261 1303 Warren Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Bertha Middle ---- Last Hausman			4. DATE OF DEATH Month Nov. Day 11, Year 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 Sept. 24, 1883		9. AGE (In years, ¹⁴⁸ birth day) Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Dress Mfg Co.		11. BIRTHPLACE (City and state or country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME John Schmitz		13b. MOTHER'S MAIDEN NAME Sophie Schroedal	
14. NAME OF HUSBAND OR WIFE Henry Hausman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 494-05-5737A	
17. INFORMANT Miss Betty Mismar		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion DUE TO (b) Coronary Occlusion DUE TO (c) 420.1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
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 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 Nov. 10 58 to Nov. 9 58 and last saw her alive on Nov. 9, 58 Death occurred at 11:58 AM on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE J. J. Vizgird (Degree or title) J. J. Vizgird M.D.		22b. ADDRESS 3511 University		22c. DATE SIGNED Nov. 11 58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-14-58		23c. NAME OF CEMETERY OR CREMATORY Lutheran	
23d. LOCATION (City, town, or county) Collinsville, Illinois		23e. FUNERAL DIRECTOR Paul C. Tronson Address 314 W. Main Collinsville, Ill			
24. DATE RECD. BY LOCAL REG. NOV 12 '58		25. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. m. j. b.			

(Licensed Embalmer's Statement on Reverse Side)

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 *Paul E. Trimmer*

Licensed Embalmer No. *7808*

P.O. Address *Collinsville*

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.