

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH **1003**
318 Registration District No. Primary Registration District No.

58-041689
STATE FILE NUMBER
Registrar's No. **10990**

FILED DEC 9 1958

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-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 type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 3154 S COMPTON		Length of stay in lb 16 d.	d. STREET ADDRESS (If outside, give location) 3154 S COMPTON Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARY Middle Last HEUSOHN			4. DATE OF DEATH Month Nov Day 14 Year 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 DEC 7, 1890	9. AGE (In years, last birthday) 67	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	11. BIRTHPLACE (City and state or country) CARMI, ILLINOIS 1		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME JACOB OTTO		13b. MOTHER'S MAIDEN NAME FANNIE HARGRAVES	14. NAME OF HUSBAND OR WIFE JOHN		
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.	17. INFORMANT JOHN HEUSOHN Address 3154 S COMPTON		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease with myocardial degeneration		INTERVAL BETWEEN ONSET AND DEATH over 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	422.1
	DUE TO (c)	
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 a.m. Month, Day, Year p.m.		
20d. INJURY OCCURRED, WHILE AT WORK <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 **26 June 1956** to **14 Nov. 1958** and last saw her alive on **8 Nov. 1958**
Death occurred at **12:50 P.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert A. Nye, M.D. (Degree or title)	22b. ADDRESS 3201 Arsenal St. St. Louis Mo.	22c. DATE SIGNED 14 Nov. 1958
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 11/17/1958	23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK	23d. LOCATION (City, town, or county) (State) AFFTON, Mo.
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24. FUNERAL DIRECTOR J L ZIEGENHEIN & SONS 7027 GRAVOIS ADDRESS	25. DATE RECD. BY LOCAL REG. NOV 15 58	26. REGISTRAR'S SIGNATURE J. Earl Smith M.D.
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(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.

H.T.

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 *E. P. Kidwell*

Licensed Embalmer No. *3877*.....

P. O. Address *7027 Gravois*.....

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.