

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041888

STATE FILE NUMBER

FILED NOV 18 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10168

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Glendale 4000.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in lb 2 Days	d. STREET ADDRESS (If outside, give location) 27 26 Glenhaven
3. NAME OF DECEASED (Type or print) First STELLA Middle B. Last LUSK			4. DATE OF DEATH Month OCTOBER Day 23 Year 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (City and state or country) Mound City Kansas
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Charles Bender	
13b. MOTHER'S MAIDEN NAME Gertrude Dawes		14. NAME OF HUSBAND OR WIFE Egbert R Lusk	
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. None	17. INFORMANT Address Eldon Lusk 26 Glenhaven
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE PASSIVE CONGESTION, LOWER LOBES, BILATERAL			INTERVAL BETWEEN ONSET AND DEATH 5-6 HOURS
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE			3-4 YEARS
DUE TO (c) 420.0			
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 checked="" type="checkbox"/> NO <input 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 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 OCT. 21, 1958 to OCT. 23, 1958 and last saw her alive on OCT. 23, 1958 Death occurred at 1:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Type or title) C. O. Vermillion, M.D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 10/24/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-25-1958	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kirkwood Mo.
24. FUNERAL DIRECTOR ADDRESS Parker-Adrich Webster-Groves Mo		25. DATE RECD. BY LOCAL REG. OCT 24 '58	26. REGISTRAR'S SIGNATURE Carl Smith Mo m & B

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Not enclosed in Part I must be causally related.

1901.5.

of 1919

of 1919

1919-1919

1919-1919

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 *Leslie Welch*.....

Licensed Embalmer No. *4395*

P. O. Address *Wester Ave*

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.