

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011035

STATE FILE NUMBER

2237

MAR 17 1959

Registration District No. _____ Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN UNION	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DEACONESS HOSP.		d. STREET ADDRESS (If outside, give location) 224 DELMAR	
3. NAME OF DECEASED (Type or print) TILLIE HUXEL		4. DATE OF DEATH Month Day Year MARCH 3, 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 5, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWORK	11. BIRTHPLACE (City and state or country) UNION, MO.
13a. FATHER'S NAME HENRY J. HOLTGREWE		13b. MOTHER'S MAIDEN NAME MINNIE LINDHORST	14. NAME OF HUSBAND OR WIFE WM. HUXEL
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT WALTER HUXEL Address WASHINGTON, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) DEEP VENOUS THROMBOSIS - LEG VEINS DUE TO (c) CARCINOMA OF GALL BLADDER PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Obstruction of Colon due to Carcinoma			INTERVAL BETWEEN ONSET AND DEATH 1 Hour 3 Wks 3 mo.
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.) 155.1	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 7:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22b. ADDRESS 1820 Carondelet	
22a. SIGNATURE Carroll J. Hamilton M.D.		22c. DATE SIGNED 3/4/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAR 6, 1959	23c. NAME OF CEMETERY OR CREMATORY ZION CEMETERY	23d. LOCATION (City, town, or country) (State) UNION MO.
24. FUNERAL DIRECTOR OLTMANN FUNERAL HOME		25. DATE RECD. BY LOCAL REG. MAR 4 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

200 2 3 4 5

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 *Ralph Altman*

Licensed Embalmer No. *4808*

P. O. Address *Union, Mo.*

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.