

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019471

STATE FILE NUMBER

FILED JUN 4 1959 Registration District No. Primary Registration District No. Registrar's No. 4991

300
1-57
6
195
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri 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 ST. LOUIS CITY HOSPITAL #1		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 203 W. Stein St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First THERESA Middle Last MUSE			4. DATE OF DEATH Month 5 Day 21 Year 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 Oct. 12, 1874
9a. AGE (In years last birthday) 84		9b. UNDER 1 YEAR Months Days	9c. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Jefferson Co., Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Phillip Ruess	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE	
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. none	17. INFORMANT Adel M. Ford Address 203 W. Stein St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) slow emphysema Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Bronchopneumonia DUE TO (c) 593x			INTERVAL BETWEEN ONSET AND DEATH
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 5-20-1959 6:15pm to 5-21-1959 and last saw her/him alive on 5-21-1959 Death occurred at 8:10 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE M. H. Meyer M.D. (Degree or title)		22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 5-21-1959
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 5-25-59	23c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery	23d. LOCATION (City, town, or county) (State) Lemay, Missouri
24. FUNERAL DIRECTOR Edward Fendler ADDRESS 5611 S. Grand Blvd.		25. DATE RECD. BY LOCAL REG. MAY 22 '59	26. REGISTRAR'S SIGNATURE Keat Smith M.D.

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 *J. O. Humphrey*

Licensed Embalmer No. # 4770

P. O. Address Sullivan, Pa.

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.