

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023724

STATE FILE NUMBER

FILED JUN 22 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1588

300
-57
0
0

1. PLACE OF DEATH a. COUNTY ST. LOUIS		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 AFFTON		c. CITY OR TOWN AFFTON 4870	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7764 ROCK HILL RD		d. STREET ADDRESS (If outside, give location) 7764 ROCK HILL RD.	
3. NAME OF DECEASED (Type or print) First FRANK Middle E. Last HUELSMAN		4. DATE OF DEATH Month JUNE Day 9 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 5, 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BLACKSMITH HELPER		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 85
11. BIRTHPLACE (City and state or country) SEDALIA, MO.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME CONRAD HUELSMAN		13b. MOTHER'S MAIDEN NAME MARY GREIVE	
14. NAME OF HUSBAND OR WIFE BESSIE HUELSMAN		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. 333-03-4324		17. INFORMANT Address MRS. FAYE LASTERN 7664 ROCK HILL RD. 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) ARTERIOSCLEROTIC HEART DISEASE DUE TO (b) ARTERIOSCLEROSIS GENERALIZED DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200			INTERVAL BETWEEN ONSET AND DEATH 4 YEARS 4 YEARS
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 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 1955 to 6/9/59 and last saw ^{him} her alive on 6/9/59 Death occurred at 9:00 PM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) George A. Nelson M.D.		22b. ADDRESS 5203 Chippewa	
22c. DATE SIGNED 6/11/59		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE 6/13/1959		23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS CEM.	
23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MO.		24. FUNERAL DIRECTOR ADDRESS SUEDMEYER SONS 3934 N. 20TH ST. ST. LOUIS 157 MO.	
25. DATE RECD. BY LOCAL REG. 6-11-59		26. REGISTRAR'S SIGNATURE John C. Murphy 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 Harvey Kahle

Licensed Embalmer No. 4596
P. O. Address St. Louis, 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.