t. Health,
, & Welfare
S. Public
lth Service

S. 300
v. 1-56
32
35

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED VS AUG 26 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-030750
STATE FILE NUMBER

Registration District No. ..... Primary Registration District No. ..... Registration No. 2 7282

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKE'S HOSP — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN St. Johns 4000 — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 8649 Ardelia — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: BABY RUESTER
4. DATE OF DEATH Month 7 Day 18 Year 59
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7 18 59
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 6 Min. 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): ST. LOUIS, MO
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: GLENNON RUESTER
14. MOTHER'S MAIDEN NAME: ERNESTINE THENHAUS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MOTHER — Address: 8649 ARDELIA, ST. LOUIS 14 MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) INTRACRANIAL ANOXIA
DUE TO (c) PREMATURE SEPARATION OF PLACENTA
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): 7610
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 7-18-59, to 7-18-59 and last saw her/him alive on 7-18-59
Death occurred at 11 A/M m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): George Shaw
22b. ADDRESS: 457 N. KINGSHIGHWAY
22c. DATE SIGNED: 7-18-59

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: 8-31-59
23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
23d. LOCATION (City, town, or county) (State): St Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS: Rowland Mortuary Svc. 4104-06 Manchester
25. DATE RECD. BY LOCAL REG.: AUG 6 59
26. REGISTRAR'S SIGNATURE: Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No..... ....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.