URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 15 1959

59–033916

STATE FILE NUMBER

ENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's 2 8796

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 22 Days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis Chronic Hosp.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 8456 Lowell (15)
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: HERMENA Middle: Last: HUIGHE
4. DATE OF DEATH: Month: Sept. Day: 22, Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 6/27/67
9. AGE (last birthday): 92
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Belgium
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Unknown Verplancke
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: John Huighe (Deceased)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Rose Belloli Address: 4115 Reaves (25) Rd. Barracks,

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) Fracture of left hip, Generalized arteriosclerosis, suffered in fall
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) from bed at Chronic Hospital on
DUE TO (c)
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) or about Sept. 2. 1959 - Accident
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown
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.) (See above) 902.7-45
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year: 9-2-59
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.): 131 Hospital
20f. CITY, TOWN, OR LOCATION: St. Louis COUNTY: STATE: Missouri

BY AFFIDAVIT OF

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at 10:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Paul J. Simon (Degree or title) Deputy Coroner
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 9/24/59
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Sept. 26, 1959
23c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cemetery
23d. LOCATION (City, town, or county) (State): Lemay (25) Mo.
24. FUNERAL DIRECTOR: Fendler Und. Co. ADDRESS: 7420 Michigan Ave. (11)
25. DATE RECD. BY LOCAL REG.: SEP 24 '59
26. REGISTRAR'S SIGNATURE: Hoard 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 embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed W. G. Peterse

Signature of Student Embalmer

Licensed Embalmer No. 3767

P. O. Address 7420 Mic

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