

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS NOV 12 1959

59-037671

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9778**

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 Saint Louis		Length of stay in 1b 45 Years		c. CITY OR TOWN Saint Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5028 Rosa Ave. (9)			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5028 Rosa Ave. (9)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LILLIE Middle E. Last HASSELBUSCH			4. DATE OF DEATH Month Oct. Day 24 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 2/8/80	9. AGE (last birthday) 79	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 At Home		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Joseph Hallada		13b. MOTHER'S MAIDEN NAME Mary Ruzika		14. NAME OF HUSBAND OR WIFE Ferdinand (Deceased)				
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 Address Sylvia McGraw 5028 Rosa Ave. (9)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis						INTERVAL BETWEEN ONSET AND DEATH 4 days		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) Chronic Interstitial Nephritis 4 Months		
DUE TO (c) Chronic Arterio Sclerosis						1 year		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 446 X						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m.		Month, Day, Year						
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 October 19th to October 24th and last saw her ^{her} _{him} alive on October 23, 1959 Death occurred at 12:55 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE W. H. Wallers M.D. (Degree or title)				22b. ADDRESS 3608 So. Grand Blvd (18)		22c. DATE SIGNED 10/26/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 27, 1959	23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem.		23d. LOCATION (City, town, or county) (State) St. Louis (16) Mo.				
24. FUNERAL DIRECTOR ADDRESS Fendler Und. Co. 7420 Michigan Ave. (11)				25. DATE RECD. BY LOCAL REG. OCT 26 1959		26. REGISTER'S SIGNATURE Loant Smith. M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr Mrs H. Walters

3608 So Grand Ave

Box 7-7891 after 9⁰⁰ Mon.

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

W. G. Peterson

Licensed Embalmer No.

3767

P. O. Address

7420 Me

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.