

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-038283**

FILED VS NOV 2 1959

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 2865

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>		Length of stay in 1b <b>14 DAYS</b>	c. CITY OR TOWN <b>University City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis County Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7823 Greensfelder La.</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>HILDEGARD Weinhalten HUGHES</b>			4. DATE OF DEATH Month Day Year <b>10 26 1959</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/9/1882</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>George W. Weinhalten</b>		13b. MOTHER'S MAIDEN NAME <b>Sophia Heinrichshofen</b>		14. NAME OF HUSBAND OR WIFE <b>David A. Hughes</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Mrs. Elizabeth H. Cullinane 7823 Greenfelder La.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>subarachnoid hemorrhage</b> DUE TO (b) <b>aneurysm rupture</b> DUE TO (c) <b>0</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					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) <b>old anterior septal myocardial infarction</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 s.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 <b>10-12-1959</b> to <b>10-26-1959</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>10-26-1959</b> Death occurred at <b>5:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>John C. Murphy, M.D.</b> (Degree or title)			22b. ADDRESS <b>601 S. Brentwood Blvd.</b>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>10/28/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri (County)</b>		
24. FUNERAL DIRECTOR ADDRESS <b>C.R. Lupton and Sons 7233 Delmar Blv'd.</b>			25. DATE RECD. BY LOCAL REG. <b>10-28-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy, M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address H. Lewis 7th

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.