

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028399

FILED VS. AUG 8 1960

318

Primary Registration District No.

1003

Registrar's No.

7320

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Mo</b> b. COUNTY			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>St Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Firmin DesLoge Hosp</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>713 Geyer</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>HAUSEL</b> Last				4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-4-1894</b>	9. AGE (last birthday) <b>65</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Erector</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Bank Building Co.</b>		11. BIRTHPLACE (City and state or country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>		
13a. FATHER'S NAME <b>John Hausel</b>			13b. MOTHER'S MAIDEN NAME <b>Anna Schmidt</b>		14. NAME OF HUSBAND OR WIFE <b>Anna Hausel</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>492-10-5331</b>		17. INFORMANT Address <b>Anna Hausel 713 Geyer</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>Hemolytic jaundice</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <b>Hodgkins Disease</b>						<b>3 months</b>	
DUE TO (c) <b>201X</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 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 <b>May 4, 1960</b> to <b>July 21, 1960</b> and last saw her/him alive on <b>July 21, 1960</b> Death occurred at <b>12:50A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>M. D.</i> (Degree or title)				22b. ADDRESS <b>4145 a S. Grand Blvd.</b>		22c. DATE SIGNED <b>7-22-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 23 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>S S Peter &amp; Paul Cem</b>		23d. LOCATION (City, town, or county) <b>St Louis</b>		Mo	
24. FUNERAL DIRECTOR <b>Thomas Kutis</b>			ADDRESS <b>2906 Gravois</b>	25. DATE RECD. BY LOCAL REG. <b>JUL 22 1960</b>		26. REGISTRAR'S SIGNATURE <i>Loard Smith M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2-10 Friday

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed: James C. Will

Licensed Embalmer No. 4347

P. O. Address 2906 Grand

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