

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

FILED JUL 18 1960

5842-60-028452  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5842**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
Length of stay in 1b <b>3 Yrs.</b>		c. CITY OR TOWN <b>University City</b> <b>4346</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bernard Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>816 Pennsylvania Ave.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
<b>LILLIAN</b>			<b>June 6, 1960</b>		
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days
<b>F.</b>	<b>W.</b>		<b>2/24/1875</b>	<b>85</b>	IF UNDER 24 HR Hours Min.
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)	12. CITIZEN OF WHAT COUNTRY	
<b>Housewife</b>		<b>Own Home</b>	<b>Columbus, Ohio</b>	<b>USA</b>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE		
<b>William Wassall</b>		<b>Sarah York</b>	<b>Herbert Henry Hughes</b>		

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 Address
<b>No</b>	<b>None</b>	<b>Bessie V. Hughes 7739 Kingsbury Ave.</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b>		<b>one week</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Heart Disease</b>	<b>2 years.</b>
	DUE TO (c) <b>Generalized arteriosclerosis</b>	<b>10 yrs.</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.
<b>4200</b>		<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 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 **July 1950** to **June 1960** and last saw him/her alive on **4 June 1960**  
Death occurred at **8:25 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
<b>Robert M. Louch, M.D.</b>	<b>52 Maryland Plaza</b>	<b>7 June 1960</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY
<b>Removal</b>	<b>6/6/1960</b>	<b>Valhalla Cemetery</b>
24. FUNERAL DIRECTOR ADDRESS		23d. LOCATION (City, town, or county) (State)
<b>Alexander &amp; Sons, Inc 6175 Delmar</b>		<b>St. Louis County, Missouri</b>

25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<b>JUN 7 1960</b>	<b>Loan Smith, M.D.</b>

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

*mjs*

Dr. Robert Launch  
52 Maryland Plaza  
Fo. T-8844

**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 John E. Miller

Licensed Embalmer No. 270

P. O. Address 6145-D

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.