

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-019784

STATE FILE NUMBER

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 1159

FILED MAY 19 1961

1. PLACE OF DEATH a. COUNTY <u>Mo</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis County</u>		c. CITY OR TOWN <u>St Louis Mo</u>	
Length of stay in 1b <u>3-years</u>		Inside Limit: Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>9101 S. Broadway</u>		d. STREET ADDRESS (If outside, give location) <u>4060 Cleveland Ave</u>	
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) First <u>John</u> Middle <u>D</u> Last <u>Huckstep Sr</u>			4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>61</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-1882</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>Ins Agent</u>	11. BIRTHPLACE (City and state or country) <u>Osage Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>James D. Huckstep</u>	13b. MOTHER'S MAIDEN NAME <u>Louise Holloway</u>	14. NAME OF HUSBAND OR WIFE <u>May</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>                    </u>	17. INFORMANT Address <u>May Huckstep 4060 Cleveland Ave</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis 3yrs</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) <u>450.0</u>		
DUE TO (c)		

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	
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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.)
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20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>  </u> <u>  </u> <u>  </u>
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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
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21. I attended the deceased from 1-29-59 to 4-23-61 and last saw him alive on 4-21-61  
Death occurred at 10:25p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <u>William A. Turner M.D.</u>	22b. ADDRESS <u>4401 Hampton</u>	22c. DATE SIGNED <u>4-24-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-26-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St Louis County MO.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Arthur J. Donnelly 3810 Lindell Blvd</u>	25. DATE RECD. BY LOCAL REG. <u>4-25-61</u>	26. REGISTRAR'S SIGNATURE <u>John E. Murphy M.D.</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 \_\_\_\_\_

Licensed Embalmer No. 4699

P. O. Address 3840 Lumb

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.