

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023478

FILED JUN 16 1961

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1540

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</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>LEMAY</u>			Length of stay in 1b <u>MONS.</u>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MOUNT ST. ROSE HOSP</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5843 KINGSWOOD DR</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <del>HUMME</del> <u>FRANCES ANN HUMME</u>				4. DATE OF DEATH Month Day Year <u>MAY 30 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 9 1884</u>	
9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>		13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
14. NAME OF HUSBAND OR WIFE <u>GUSTAV HUMME (DECD)</u>		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>NONE</u>		17. INFORMANT Address <u>GUS HUMME 5843 KINGSWOOD DR</u>	
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>Pulmonary Infarction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24-48 hrs</u>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) <u>Thrombus in Pulmonary Artery</u>							<u>24-48 hrs</u>
DUE TO (c) <u>Generalized Arteriosclerosis yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Encephalomalacia (6 mo)</u>					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 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 <u>5-23-61</u> to <u>5-30-61</u> and last saw her alive on <u>5-29-61</u> Death occurred at <u>5:05 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>William A. Stutis M.D.</u>				22b. ADDRESS <u>4401 Hampton</u>		22c. DATE SIGNED <u>6-1-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JUNE 2, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM.</u>		23d. LOCATION (City, town, or county) <u>ST. LOUIS CO. MO.</u>	
24. FUNERAL DIRECTOR <u>Thomas Stutis</u>		ADDRESS <u>2906 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>6-1-61</u>		26. REGISTRAR'S SIGNATURE <u>John B. Mayfield M.D.</u>	

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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 James C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 ...

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.

*[Handwritten scribble]*