

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035070

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8293**

STATE FILE NUMBER

1. PLACE OF DEATH
 a. COUNTY
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis** Length of stay in 1b
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **D.O.A. City Hospital** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **Mo.** b. COUNTY
 c. CITY OR TOWN **St. Louis** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **5425a S. Broadway** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **EMMA** Middle Last **VENN** 4. DATE OF DEATH Month **Sep.** Day **5** Year **1961**

5. SEX **Female** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **9-14-1865** 9. AGE (last birthday) **95** 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) **Box Maker (Retired) Schleicher Box Co.** 10b. KIND OF BUSINESS OR INDUSTRY **St. Louis, Mo.** 11. BIRTHPLACE (City and state or country) **U.S.A.** 12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME **Otto Venn** 13b. MOTHER'S MAIDEN NAME **Mary Mussman** 14. NAME OF HUSBAND OR WIFE -----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT **Mamie Suessdorf** Address **5425a S. Broadway**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Arterio Sclerotic Heart Disease**
 DUE TO (b) **420.0**
 DUE TO (c)
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 _____ to _____ and last saw her/him alive on _____
 Death occurred at _____ **6:00 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **[Signature]** 22b. ADDRESS **1300 Clark** 22c. DATE SIGNED **9-6-61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **Sep. 8, 1961** 23c. NAME OF CEMETERY OR CREMATORY **New St. Marcus Cemetery** 23d. LOCATION (City, town, or county) (State) **St. Louis Co. Mo.**

24. FUNERAL DIRECTOR ADDRESS **Kriegshausler 4228 S. Kingshighway Blvd.** 25. DATE RECD. BY LOCAL REG. **SEP 6 1961** 26. REGISTRAR'S SIGNATURE **[Signature]**

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 ITEM NO.

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 William B White

Licensed Embalmer No. 4291

P. O. Address _____

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.