

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-038742

STATE FILE NUMBER

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9236**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois COUNTY Marion	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis	Length of stay in 1b 18 Days	c. CITY OR TOWN Centralia	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 221 S. Cherry	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ELSE Middle CATHERINE Last HUSSMANN			4. DATE OF DEATH Oct. 5, 1961		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/19/88	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teacher	11. BIRTHPLACE (City and state or country) Atlanta, Ga.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME William Rex		13b. MOTHER'S MAIDEN NAME Helena Boerger		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. Unknown	17. INFORMANT Mrs. Fredia Jones, Centralia, Ill.	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs.
IMMEDIATE CAUSE (a)	Metastatic Malignant Melanoma of Liver	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	Primary Malignant Melanoma, Right Eye	
	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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
192x			

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.) 192x
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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 Centralia, Ill.	COUNTY Marion	STATE Ill.
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21. I attended the deceased from **9-18-61** to **10-5-61** and last saw her alive on **10-5-61**
Death occurred at **7:00 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Theo H. Hansen M.D.	(Degree or title)	22b. ADDRESS 3701 GRANDER SQ.	22c. DATE SIGNED 10/16/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-7-61	23c. NAME OF CEMETERY OR CREMATORY Hillcrest	23d. LOCATION (City, town, or county) Sandoval, Ill.
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24. FUNERAL DIRECTOR Queen-Boggs, Centralia, Ill.	ADDRESS	25. DATE RECD. BY LOCAL REG. OCT 6 1961	26. REGISTRAR'S SIGNATURE Earl Smith M.D.
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

Dr. HANSEN.
3701 GRANDEL SQUARE.

STATEMENT BY LICENSED EMBALMER

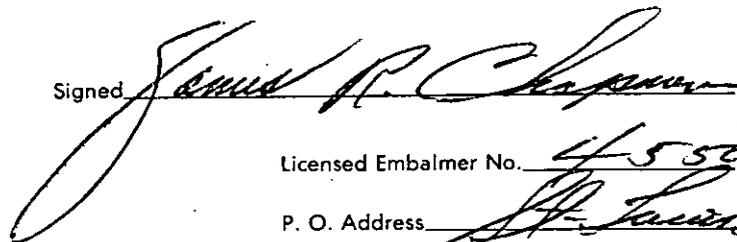
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4550

P. O. Address St. Louis

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.