

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

= 62-003691

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 815

AMENDED

FILED JAN 25 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived... if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri Baptist</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5008 Wren Avenue.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle Last <u>DUISEN</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>17,</u> Year <u>1962</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>12/15/1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (last birthday) <u>84</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) <u>New Haven, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charles Blasko</u>		13b. MOTHER'S MAIDEN NAME <u>Wilhelmina Karschnick</u>	
14. NAME OF HUSBAND OR WIFE <u>Deceased</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. E. H. Cune 10431 Page Ave.</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>Fracture of right hip, Arterio Sclerosis.</u> DUE TO (b) <u>Suffered in fall in home on 12-17-61</u> DUE TO (c) <u>accident 904.0-21</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>See above</u>	
20c. TIME OF INJURY Hour <u>2</u> a.m. p.m. Month, Day, Year <u>12-17-61</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>o7 Home</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis, Mo</u> COUNTY STATE	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Paul Simon</u> (Degree or title) <u>Deputy Coroner</u>		22b. ADDRESS <u>1300 Clark</u>	
22c. DATE SIGNED <u>1/18/62</u> (State)		22d. LOCATION (City, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1/20/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Evn. Cemetery - New Haven, Mo.</u>	
24. FUNERAL DIRECTOR <u>JOHN STYGAR & SON - 5541 RIVERVIEW BLVD.</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 18 1962</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY 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 *J. M. Rister*

Licensed Embalmer No. 3980

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.