

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318      1003      8221 - 62-032875  
 Registration District No.      Primary Registration District No.      Registrar's No.      STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED SEP 10 1962**

VS 300  
Rev. 4/59

1

2 *21*

3

4 *1*

5 *0*

6

7 *2*

8 *2*

9

10

11

12 *92-3*

13

*91*

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. City Hospital</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4167 Cleveland Ave.</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First      Middle      Last <b>LINA      F.      SAUSSELE</b>			4. DATE OF DEATH Month      Day      Year <b>Aug.      22      1962</b>										
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>6-23-1890</b>		9. AGE (last birthday) <b>72</b>		IF UNDER 1 YEAR Months      Days		IF UNDER 24 HR Hours      Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Charles F. Saussele</b>				13b. MOTHER'S MAIDEN NAME <b>Louisa Haiges</b>				14. NAME OF HUSBAND OR WIFE <b>-----</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No      None</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Frieda Mueller 4167 Cleveland Ave.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease.</b> DUE TO (b) <b>Generalized Arterio Sclerosis.</b> DUE TO (c) <b>4200</b> 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. <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 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      Month, Day, Year a.m.      p.m.		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 _____, to _____ and last saw her/him alive on _____ Death occurred at _____ <i>133 P</i> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>Paul J. Simon</i> <i>Deputy Coroner</i>				22b. ADDRESS <i>1300 Clark</i>				22c. DATE SIGNED <i>8/23/62</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		23e. (State)					
<b>Removal</b>		<b>Aug. 25, 1962</b>		<b>Valhalla Cemetery</b>		<b>St. Louis Co. Mo.</b>							
24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>AUG 23 1962</b>		26. REGISTRAR'S SIGNATURE <i>Robert Smith, M.D.</i>							

## 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 R. Dunn*

Licensed Embalmer No. 4527

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.