

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registered District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1474**

-63-008827
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 19 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 mos.	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 623 Hamilton		
3. NAME OF DECEASED (Type or print) First RUTH Middle AGNES Last HUSMAN			4. DATE OF DEATH Month Feb. Day 8, Year 1963			
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 5/27/1892	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Printing Co.	11. BIRTHPLACE (City and state or country) New York N. Y.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Clarence P. Wilkerson		13b. MOTHER'S MAIDEN NAME Elizabeth Corrigan		14. NAME OF HUSBAND OR WIFE Herbert Husman		
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. [REDACTED]	17. INFORMANT Address Melbourne Husman 623 Hamilton			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LAENNEC CIRRHOSIS OF LIVER					INTERVAL BETWEEN ONSET AND DEATH YEARS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 5811					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	
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 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 1955 to 8 FEB 1963 and last saw her him alive on 8 FEB 1963 Death occurred at 5-30 PM m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE Robert A. Mayer MD (Degree or title)			22b. ADDRESS 950 FRANCIS PL CLAYTON, MO		22c. DATE SIGNED 2/11/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/12/63	23c. NAME OF CEMETERY OR CREMATORY Galvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Mo.		
24. FUNERAL DIRECTOR Cullen Kelly ADDRESS 7267 Natural Bridge		25. DATE RECD. BY LOCAL REG. FEB 11 1963	REGISTRAR'S SIGNATURE Paul Smith, M.D.			

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 H. Lammner

Licensed Embalmer No. 4142

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.