

300
48

10816
3136

FILED APR 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No.

Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No.		Registrar's No.											
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, write RURAL and give township) OR TOWN <u>St. Louis</u>				c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>													
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1725 Bacon st</u>															
3. NAME OF DECEASED (Type or Print) <u>LOUISE</u>			a. (First)			b. (Middle)			c. (Last) <u>WESTPHALEN</u>										
4. DATE OF DEATH <u>April 5 1949</u>			5. SEX <u>female</u>			6. COLOR OR RACE <u>white</u>			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>										
8. DATE OF BIRTH <u>Jan. 26, 1891</u>			9. AGE (In years last birthday) <u>58</u>			10. MONTHS <u>2</u>			11. DAYS <u>7</u>										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>				11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? _____									
13a. FATHER'S NAME <u>Julius Kritz</u>				13b. MOTHER'S MAIDEN NAME <u>not known</u>				14. NAME OF HUSBAND OR WIFE <u>John H. Westphalen</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>no</u>			17. INFORMANT'S SIGNATURE OR NAME <u>John H. Westphalen</u>					ADDRESS <u>1725 Bacon st</u>								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.										MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Gastric hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>gastric ulcer</u> DUE TO (c) <u>11/7</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION <u>11-12-1948</u>				19b. MAJOR FINDINGS OF OPERATION <u>gastric ulcer (large)</u>						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>				21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____				21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____											
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21f. HOW DID INJURY OCCUR? _____											
22. I hereby certify that I attended the deceased from <u>11-11</u> ¹⁹⁴⁸ to <u>4-5</u> ¹⁹⁴⁹ , that I last saw the deceased alive on <u>11-5</u> ¹⁹⁴⁸ , and that death occurred at <u>P</u> ^{11:45} m., from the causes and on the date stated above.																			
23a. SIGNATURE <u>D. J. Ueda</u> (Degree or Title) <u>MO</u>						23b. ADDRESS <u>Sister Bldg St Louis</u>			23c. DATE SIGNED <u>4-6-49</u>										
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			24b. DATE <u>Apr. 9, 1949</u>			24c. NAME OF CEMETERY OR CREMATORY <u>Bethany Cemetery</u>			24d. LOCATION (City, town, or county) (State) <u>6800 Easton ave Mo</u>										
DATE REC'D BY LOCAL REG. <u>APR 7 1949</u>				REGISTRAR'S SIGNATURE <u>J. B. Pasater</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>A. Aron L & U Co</u> ADDRESS <u>2707 North Blvd</u>											

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Signed.....

Stanley H. Lison

Signed.....

Student Embalmer

Licensed Embalmer No.

4193

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.)

o) If this body is not embalmed, fact should be so stated above.