

FILED SEP 9 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27254

BIRTH NO. 124 REG. DIST. NO. 163 PRIMARY REG. DIST. NO. 5596 Registrar's No. 49

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Jefferson  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE<br>Missouri |  | b. COUNTY<br>Jefferson   |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN<br>De Sota Rural-Valle |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN<br>De Sota                    |  | d. STREET ADDRESS (If rural, give location)<br>Star Route West |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br>Star Route West   |  | d. STREET ADDRESS   |  |  |  |

|   |  |  |            |  |  |             |  |  |           |  |  |  |  |  |
|---|--|--|------------|--|--|-------------|--|--|-----------|--|--|--|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) Fréd |  |  | a. (First) |  |  | b. (Middle) |  |  | c. (Last) |  |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br>Sept 3, 1949 |  |  |
|---|--|--|------------|--|--|-------------|--|--|-----------|--|--|--|--|--|

|                |  |                           |  |   |  |                                  |  |                                       |  |                                  |  |                                |  |
|----------------|--|---------------------------|--|---|--|----------------------------------|--|---------------------------------------|--|----------------------------------|--|--------------------------------|--|
| 5. SEX<br>Male |  | 6. COLOR OR RACE<br>White |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>Married |  | 8. DATE OF BIRTH<br>July 2, 1880 |  | 9. AGE (In years last birthday)<br>69 |  | 10. IF UNDER 1 YEAR/ Months Days |  | 11. IF UNDER 2 HRS. Hours Min. |  |
|----------------|--|---------------------------|--|---|--|----------------------------------|--|---------------------------------------|--|----------------------------------|--|--------------------------------|--|

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|--|--|--|--|---|--|--|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Retired |  | 11. BIRTHPLACE (State or foreign country)<br>St. Louis, Mo. |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |  |
|--|--|--|--|---|--|--|--|--|--|

|                                      |  |  |  |  |  |                                      |  |  |
|--------------------------------------|--|--|--|--|--|--------------------------------------|--|--|
| 13a. FATHER'S NAME<br>Henry Preusser |  |  | 13b. MOTHER'S MAIDEN NAME<br>Minnie Orth |  |  | 14. NAME OF HUSBAND OR WIFE<br>Edith |  |  |
|--------------------------------------|--|--|--|--|--|--------------------------------------|--|--|

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|--|--|--|--|---|--|--|--|---------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No |  | 16. SOCIAL SECURITY NO.<br>498-16-1469 |  | 17. INFORMANT'S SIGNATURE OR NAME<br>Edith Preusser, De Sota, Mo. |  |  |  | ADDRESS |  |
|--|--|--|--|---|--|--|--|---------|--|

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|---|--|--|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of colon, ascending and transverse.</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |  |  |  | INTEGRAL BETWEEN ONSET AND DEATH<br><br>1 year<br><br>153X |  |
|---|--|--|--|--|--|--|--|--|--|

|                        |  |                                  |  |  |  |   |  |
|------------------------|--|----------------------------------|--|--|--|---|--|
| 19a. DATE OF OPERATION |  | 19b. MAJOR FINDINGS OF OPERATION |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
|------------------------|--|----------------------------------|--|--|--|---|--|

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) |  | 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) (Min.) |  | 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 April 4, 1949, to Sept 3, 1949, that I last saw the deceased alive on Sept 2, 1949, and that death occurred at 2:00 pm., from the causes and on the date stated above.

|   |  |                   |  |  |  |                                   |  |
|---|--|-------------------|--|--|--|-----------------------------------|--|
| 23a. SIGNATURE<br><u>Thomas A. Donnell MD</u> |  | (Degree or title) |  | 23b. ADDRESS<br><u>16 Boyd St. De Sota, Mo</u> |  | 23c. DATE SIGNED<br><u>9-3-49</u> |  |
|---|--|-------------------|--|--|--|-----------------------------------|--|

|   |  |                            |  |  |  |   |  |
|---|--|----------------------------|--|--|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial |  | 24b. DATE<br>Sept. 7, 1949 |  | 24c. NAME OF CEMETERY OR CREMATORY<br>Sunset Burial Park Cem., St. Louis County, Mo. |  | 24d. LOCATION (City, town, or county) (State) |  |
|---|--|----------------------------|--|--|--|---|--|

|                                    |  |  |  |     |  |  |  |   |  |
|------------------------------------|--|--|--|-----|--|--|--|---|--|
| DATE REC'D BY LOCAL REG.<br>9/6/49 |  | REGISTRAR'S SIGNATURE<br><u>Marie Harris</u> |  | 146 |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Waska Helms U. &amp; L. Co.</u> |  | ADDRESS<br>3634 Gravois<br>St. Louis, Mo. |  |
|------------------------------------|--|--|--|-----|--|--|--|---|--|

FEB 1 1950

SEP 13 1949  
District File Number

District Health Officer No. 9

RECEIVED  
SEP 7 1949

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 .....  
Student Embalmer

Signed *Delis J. Krupin*

Licensed Embalmer No. *3497*

P. O. Address *3634 Gravois*

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