

FILED SEP 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31740
7077
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

| | | | |
|--|--|--|--|
| 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, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (In this place) Mo. 2 mos. | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hosp. | | e. STREET ADDRESS (If rural, give location) 7118 Natl Bridge | |

| | | | | | | |
|---|-----------------------|---|--|---|-----------------------------|----------------------------------|
| 3. NAME OF DECEASED (Type or Print) Clara Hughes Essmann | | | 4. DATE OF DEATH (Month) (Day) (Year) Aug 13 49 | | | |
| 5. SEX F / W | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, Married | 8. DATE OF BIRTH Feb. 22, 1892 | 9. AGE (In years last birthday) 57 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) St. Louis | | 12. CITIZEN OF WHAT COUNTRY? USA |

| | | |
|-------------------------------------|---|---|
| 13a. FATHER'S NAME August Griese | 13b. MOTHER'S MAIDEN NAME Elizabeth German | 14. NAME OF HUSBAND OR WIFE H. Carl Essman |
|-------------------------------------|---|---|

| | | |
|--|------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none | 16. SOCIAL SECURITY NO. none | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS H. Carl Essman 7118 Nat. Bridge |
|--|------------------------------|--|

| | | | |
|---|---|--|--|
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 3 mo |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Retroperitoneal Sarcoma | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

| | | |
|-----------------------------------|---|---|
| 19a. DATE OF OPERATION 7/13/49 | 19b. MAJOR FINDINGS OF OPERATION Sarcoma | 20. AUTOPSY? 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) H10 |
| 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? 1981 |

22. I hereby certify that I attended the deceased from 6/18, 1949, to 8/13, 1949 that I last saw the deceased alive on 8/12, 1949, and that death occurred at 8:40 a.m., from the causes and on the date stated above.

| | | |
|---|-----------------------------|-----------------------------|
| 23a. SIGNATURE (Degree or title) H. H. Hayden M.D. | 23b. ADDRESS 5899 Delmar | 23c. DATE SIGNED 8/13/49 |
|---|-----------------------------|-----------------------------|

| | | | |
|---|--------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | 24b. DATE Aug 15 1949 | 24c. NAME OF CEMETERY OR CREMATORY Lakewood Park | 24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo |
|---|--------------------------|---|---|

| | | |
|---|---|--|
| DATE REC'D BY LOCAL REG. AUG 15 1949 | REGISTRAR'S SIGNATURE J. B. Sabatini | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Alexander & Sons 6175 Delmar |
|---|---|--|

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.

Student
Student Embalmer

Signed

Joseph E. McCulloch

Licensed Embalmer No. 2460

P. O. Address 615 5th St

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.