

S. No. 300
v. 10-48

FILED OCT 19 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35679

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2457

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Pine Lawn</u>		c. LENGTH OF STAY (in this place) <u>1 Yr.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>O'Sullivan Nursing Home</u>		d. STREET ADDRESS (If rural, give location) <u>3240 Charlack Ave</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Angeline</u> b. (Middle) <u>Amelia</u> c. (Last) <u>Aug</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>10-11-1950</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10-5-1874</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Month <u>0</u> Days <u>6</u>	IF UNDER 24 HRS. Hour <u>6</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Summerfield, Ill.</u>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <u>Peter Lippert</u>	13b. MOTHER'S MAIDEN NAME <u>Gatherine Riley</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Aug</u>
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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)	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Adele M Aug</u>	ADDRESS <u>3240 Charlack Ave</u>
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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, asphyxia, etc.; it means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cachexia + multiple decubiti</u>		<u>3 months</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Cerebral hemorrhage</u>	<u>5 mo</u>
		DUE TO (c) <u>Hypertensive Cardio-vascular disease</u>	<u>5 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Senile dementia</u> <u>Arteriosclerosis</u>	<u>14 3/4</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Feb 27, 1949, to Oct 11, 1950, that I last saw the deceased alive on Oct 9, 1950, and that death occurred at 7:10 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Lewis Littman</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>8231 Clayton Rd (17)</u>	23c. DATE SIGNED <u>10/12/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-14-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
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DATE REC'D BY LOCAL REG. <u>OCT 13 1950</u>	REGISTRAR'S SIGNATURE <u>H. Domke M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Drehmann-Harral</u>	ADDRESS <u>1905 Union Blvd</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

8231 Carey Lane RR.
3-5-57

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 Warren R. Casne

Licensed Embalmer No. 3534

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