

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25683

State File No.

FILED AUG 15 1951

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2771

1. PLACE OF DEATH
a. COUNTY ST. LOUIS 4670

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) ROCH

c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS 2269

d. FULL NAME OF HOSPITAL OR INSTITUTION ROBERT KOCH HOSPITAL

d. STREET ADDRESS (If rural, give location) 2805 a. N 10 (Near)

3. NAME OF DECEASED
a. (First) HELEN b. (Middle) GERTRUDE c. (Last) ASQUE

4. DATE OF DEATH (Month) (Day) (Year) July 23, 1951

5. SEX Female

6. COLOR OR RACE N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Feb 23, 1910

9. AGE (In years last birthday) 41 If over 1 year: Months _____ Days _____ If under 1 year: Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maid

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) Jefferson City, Mo

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME FINNER ENGLAND

13b. MOTHER'S MAIDEN NAME GENEVIEVE BROOKS

14. NAME OF HUSBAND OR WIFE WILLIE ASQUE

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. _____

17. INFORMANT'S SIGNATURE OR NAME Hospital Record ADDRESS Koch Hospital

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, ashenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Preliminary Tuberculosis
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) _____
DUE TO (c) 002X
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Intestinal Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH
9 mo +

5 mo ±

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

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) (Minute) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Feb 23, 1951, to July 23, 1951, that I last saw the deceased alive on July 23, 1951, and that death occurred at 11:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank Cohen MD

23b. ADDRESS Robert Koch Hosp. KOCH MO

23c. DATE SIGNED July 24/51

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/28/51

24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery

24d. LOCATION (City, town, or county) (State) St. Louis, Missouri

DATE REC'D BY LOCAL REG. 7-26-51

REGISTRAR'S SIGNATURE Herbert P. Dornke MD

25. FUNERAL DIRECTOR'S SIGNATURE GATES FUNERAL HOME ADDRESS Charles J. Gates, 4107 Finney Ave.

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 *John K. Cunningham*

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

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.