

FILED FEB 2 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3379

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **0589**

1. PLACE OF DEATH a. COUNTY		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) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) ST LOUIS	
c. LENGTH OF STAY (in this place) 5 days		d. DATE OF DEATH (Month) (Day) (Year) Jan. 18 1952	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital # 1		e. STREET ADDRESS (If rural, give location) 4416 Chouteau Ave	

3. NAME OF DECEASED (Type or Print) a. (First) HATTIE b. (Middle) c. (Last) STUECKRATH			4. DATE OF DEATH (Month) (Day) (Year) Jan. 18 1952		
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH 1/25/1882	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 11 Days 7

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Reamsville Kansas	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Alfred SAWWARTZ	13b. MOTHER'S MAIDEN NAME Pauline KAPISCH	14. NAME OF HUSBAND OR WIFE MARTIN STUECKRATH	

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 ADDRESS Ms Helma Fox 4416 Chouteau St Louis	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Rectum i Cerebral metastases		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity 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. Cerebral Thrombosis		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 134X
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22. I hereby certify that I attended the deceased from **1/13 1952** to **1/18 1952**, that I last saw the deceased alive on **1/18 1952**, and that death occurred at **4:00 PM**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Jarvis P. Poulos, M.D.	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 1-19-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1/21/52	24c. NAME OF CEMETERY OR CREMATORY ST. PETERS CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 21 1952 Paul Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bull Campbell Mortuary 4215 Lindell
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1-19-54
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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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed ~~St Louis~~ *Rex Campbell*

Signed _____
Student Embalmer

Licensed Embalmer No. 3881

P. O. Address St Louis 8, Mo

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.