

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10527
2996

State File No.

FILED APR 12 1952

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No.

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 town) St. Louis, Missouri		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2169	
3. NAME OF DECEASED (Type or Print) a. (First) FREIDA b. (Middle) MAE c. (Last) RUSH		4. DATE OF DEATH (Month) (Day) (Year) MARCH 29, 1952	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 6, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY XXXXXXXXXXXX	9. AGE (In years last birthday) 74 IF UNDER 1 YEAR Months IF UNDER 4 HRS. Days IF UNDER 4 HRS. Hours Min.
11a. FATHER'S NAME John Cull		11b. MOTHER'S MAIDEN NAME Unknown	11. BIRTHPLACE (State or foreign country) St. Louis, Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.		14. NAME OF HUSBAND OR WIFE Herman Rush	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No XXXXXXXXXX		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bessie Matheny, 3526 Humphrey
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Encyphalomalacia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral thrombosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Hypertensive cardiovascular disease	
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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 332X	
22. I hereby certify that I attended the deceased from 3-25-52 , 19___, to 3-29-52 , 19___, that I last saw the deceased alive on 3-29-52 , 19___, and that death occurred at 6:10A m. , from the causes and on the date stated above.			
23a. SIGNATURE John T. Lawton		(Degree or title) M.D.	23b. ADDRESS 1515 Lafayette Avenue
23c. DATE SIGNED 3-29-52			
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE April 1, 1952	24c. NAME OF CEMETERY OR CREMATORY St. Matthew Cemetery, St. Louis Co., Mo.	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. MAR 31 1952	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacker-Heldreth and Co., 3634 Gravois Ave	

WRITE PLAINLY—USING UNEADING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Frank J. Lawler Jr.

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

*2645
W. Lincoln*

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.