

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15752**
Registrar's No. **3543**

FILED APR 18 1953

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

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri. b. COUNTY 2209			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		e. STREET ADDRESS (If rural, give location) 2519a University Street. 20			
3. NAME OF DECEASED (Type or Print) a. (First) ALBERT b. (Middle) C. c. (Last) HAGEBUSCH			4. DATE OF DEATH (Month) (Day) (Year) APRIL 2, 1953		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 1, 1906	9. AGE (In years last birthday) 46	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) Dock Hand		10b. KIND OF BUSINESS OR INDUSTRY Be Mac Truck Co.		11. BIRTHPLACE (City and State or Foreign Country) Okawville, Ills.	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME William F. Hagebusch		13b. MOTHER'S MAIDEN NAME Maggie Gibbs.	
14. NAME OF HUSBAND OR WIFE Ruth Hagebusch.		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 Ruth Hagebusch, 2519a University St.		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) Acute Delemin Tremors ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Vitamin Deficiencies DUE TO (c) Chronic Alcoholism II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 307X	
22. I hereby certify that I attended the deceased from 3-30-53, 19 , to 4-2-53, 19 , that I last saw the deceased alive on 4-2-53, 19 , and that death occurred at 1:00A m. , from the causes and on the date stated above.					
23a. SIGNATURE Albert E. Stock MD		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 4-2-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Apr. 4, 1953		24c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cem, Okawville, Illinois.	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE J. Earl Smith, MD.		ADDRESS Leidner Und. Co. 2223 St. Louis Ave.	

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.....
Signature of Student Embalmer

Signed *G. W. Wilkinson*.....

Licensed Embalmer No. *357*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.