

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45294

FILED JAN 19 1954

State File No. 12029
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 12029		Registrar's No. _____					
1. PLACE OF DEATH a. COUNTY 0				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cape Girardeau									
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 Jacks on		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>							
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital				e. STREET ADDRESS (If rural, give location) Farmington Road		0161							
3. NAME OF DECEASED (Type or Print) a. (First) Elda			b. (Middle)			c. (Last) Fluegge			4. DATE OF DEATH (Month) (Day) (Year) Dec 18, 1953				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Mar 14 1896		9. AGE (In years last birthday) 57		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) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and State or Foreign Country) Gordonville, Missouri			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13a. FATHER'S NAME Henry Bodensline				13b. MOTHER'S MAIDEN NAME Anna Kester				14. NAME OF HUSBAND OR WIFE Alvin Fluegge					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil				16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Alvin Fluegge, Jackson, Missouri.							
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thyrototoxicosis ANTECEDENT CAUSES Diffuse Toxic Goiter Morbid 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.						INTERVAL BETWEEN ONSET AND DEATH 1 yr 15 yrs					
19a. DATE OF OPERATION 9/18/53		19b. MAJOR FINDINGS OF OPERATION Substernal Goiter						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 2520		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 10, 1953 to Dec 18, 1953 , that I last saw the deceased alive on Dec 18, 1953 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above.													
23. SIGNATURE (Degree or title) Emmett H. Houshka M.D.						23b. ADDRESS 10600 Central			23c. DATE SIGNED 18 Dec 1953				
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-22-53		24c. NAME OF CEMETERY OR CREMATORY Russell Heights		24d. LOCATION (City, town, or county) (State) Jackson, Missouri.							
DATE REC'D BY LOCAL REG. DEC 21 1953		REGISTRAR'S SIGNATURE Carl Smith M.D.				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd							

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.....
Signature of Student Embalmer

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

Licensed Embalmer No. *35*

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.**