

10. 300  
0. 48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 30 1955

State File No. **20423**  
**4745**  
Registrar's No. ....

|                                                                                                                                                                                                                                                    |                               |                                                                                                        |                                                                     |                                                                                                                                               |                                           |                                                                                                                        |                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| BIRTH NO. _____                                                                                                                                                                                                                                    |                               | REG. DIST. NO. <b>318</b>                                                                              |                                                                     | PRIMARY REG. DIST. NO. <b>1003</b>                                                                                                            |                                           | Registrar's No. ....                                                                                                   |                                                  |
| 1. PLACE OF DEATH<br>a. COUNTY _____                                                                                                                                                                                                               |                               |                                                                                                        |                                                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |                                           |                                                                                                                        |                                                  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>                                                                                                                                                      |                               | c. LENGTH OF STAY (in this place) _____                                                                |                                                                     | c. CITY OR TOWN <b>University City</b>                                                                                                        |                                           | 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 <b>Hamilton Medical Center</b>                                                                                                                                                                             |                               |                                                                                                        |                                                                     | f. STREET ADDRESS (If rural, give location) <b>756 Harvard</b>                                                                                |                                           |                                                                                                                        |                                                  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>ADELE</b> b. (Middle) <b>GERTRUDE</b> c. (Last) <b>STAUDE</b>                                                                                                                                 |                               |                                                                                                        | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>29</b> Year <b>1955</b> |                                                                                                                                               |                                           |                                                                                                                        |                                                  |
| 5. SEX <b>Female</b>                                                                                                                                                                                                                               | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>                                  | 8. DATE OF BIRTH <b>June 19, 1860</b>                               |                                                                                                                                               | 9. AGE (In years last birthday) <b>94</b> | 10. IF UNDER 1 YEAR Days <b>11</b> Hours <b>10</b>                                                                     | 11. IF UNDER 24 HRS. Hours <b>10</b> Mins. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>                                                                                                                                       |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>                                                       |                                                                     | 11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>                                                                 |                                           | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                             |                                                  |
| 13a. FATHER'S NAME <b>Theodore Carl Koch</b>                                                                                                                                                                                                       |                               | 13b. MOTHER'S MAIDEN NAME <b>Anna Kirschbaum</b>                                                       |                                                                     | 14. NAME OF HUSBAND OR WIFE <b>Oscar A. Staude</b>                                                                                            |                                           |                                                                                                                        |                                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>                                                                                                                                                                        |                               | 16. SOCIAL SECURITY NO. <b>None</b>                                                                    |                                                                     | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Otto Kortkamp 5833 Devonshire</b>                                                                |                                           |                                                                                                                        |                                                  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><i>* This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>                 |                               |                                                                                                        |                                                                     |                                                                                                                                               |                                           |                                                                                                                        |                                                  |
| <b>MEDICAL CERTIFICATION</b>                                                                                                                                                                                                                       |                               |                                                                                                        |                                                                     |                                                                                                                                               |                                           |                                                                                                                        |                                                  |
| 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart Disease</b>                                                                                                                                                       |                               | INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>                                                         |                                                                     |                                                                                                                                               |                                           |                                                                                                                        |                                                  |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Senile Changes</b><br>DUE TO (c) _____                                                                      |                               |                                                                                                        |                                                                     |                                                                                                                                               |                                           |                                                                                                                        |                                                  |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>                                                                                                    |                               |                                                                                                        |                                                                     |                                                                                                                                               |                                           |                                                                                                                        |                                                  |
| 19a. DATE OF OPERATION _____                                                                                                                                                                                                                       |                               | 19b. MAJOR FINDINGS OF OPERATION _____                                                                 |                                                                     |                                                                                                                                               |                                           | 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) _____                                                                                         |                                           |                                                                                                                        |                                                  |
| 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 <b>4200</b>                                                                                                         |                                           |                                                                                                                        |                                                  |
| 22. I hereby certify that I attended the deceased from <b>Feb. 19 55</b> , to <b>May 29 55</b> , that I last saw the deceased alive on <b>May 29 55</b> and that death occurred at <b>4:00P m.</b> , from the causes and on the date stated above. |                               |                                                                                                        |                                                                     |                                                                                                                                               |                                           |                                                                                                                        |                                                  |
| 23a. SIGNATURE (Degree or title) <b>Joseph Davis - M.D.</b>                                                                                                                                                                                        |                               |                                                                                                        |                                                                     | 23b. ADDRESS <b>906 Olive St.</b>                                                                                                             |                                           | 23c. DATE SIGNED <b>5/29/55</b>                                                                                        |                                                  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>                                                                                                                                                                                         |                               | 24b. DATE <b>June 1, 1955</b>                                                                          |                                                                     | 24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Chapel</b>                                                                                    |                                           | 24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>                                        |                                                  |
| DATE REC'D BY LOCAL REG. <b>MAY 31 1955</b>                                                                                                                                                                                                        |                               | REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>                                                             |                                                                     | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ambruster Mortuary, 6633 Clayton Rd.</b>                                                          |                                           |                                                                                                                        |                                                  |

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

(Licensed Embalmer's Statement on Reverse Side)

---

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.....

Licensed Embalmer No. *47*

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.