

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

45573

STATE FILE NUMBER

FILED JAN 13 1958

318

1003

12625

Registration District No. Primary Registration District No. Registrar 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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Desloge Hospital			Length of stay in 1b 5 days 27	d. STREET ADDRESS 2166 Tower Grove Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude N. Austin			4. DATE OF DEATH Month Day Year 12 28 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1892	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Little Rock, Ark.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Samuel Strickland			14. MOTHER'S MAIDEN NAME Mary Duke		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.	17. INFORMANT Address Renold F. Strickland 6315 Henry Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BERRY ANEURYSM Rupture DUE TO (b) Hypertension DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 12/23 to 12/28 and last saw her alive on 12/28 Death occurred at 8:55 Am on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Robert L. Kestner, M.D.			22b. ADDRESS 1325 S. Grand		22c. DATE SIGNED 12/28/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec. 31, 1957	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. DEC 30 57	26. REGISTRAR'S SIGNATURE Carl Smith MO		

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..... *Richard H. Stover*

Licensed Embalmer No..... 400

P. O. Address

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.