

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007686
STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. Primary Registration District No. Registrar No. 1503

300
-57
6
295
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>ST LOUIS</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. LOUIS CITY HOSPITAL #1.</i>		Length of stay in lb <i>0</i>	d. STREET ADDRESS <i>6119 WANDA</i> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>ELSA A. SUESS</i>			4. DATE OF DEATH Month Day Year <i>2 - 9 - 1959</i>		
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC 4, 1892</i>	9. AGE (In years last birthday) <i>66</i>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during part of life, even if retired) <i>AT HOME</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>ST LOUIS MO. C</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13a. FATHER'S NAME <i>LOUIS HINTZE</i>		13b. MOTHER'S MAIDEN NAME <i>ANTOINETTE WIECHMANN</i>		14. NAME OF HUSBAND OR WIFE <i>ALFRED SUESS</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>ALFRED SUESS</i> Address <i>6119 WANDA</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary thrombosis</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>metastizing catitis</i>		
	DUE TO (c) <i>Brain tumor (pituitary?)</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <i>5711</i>			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 <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 *2-7-1959* to *2-9-1959* and last saw her alive on *2-9-1959*
Death occurred at *5:20 P.M.* m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Name or title) <i>Joseph P. Babka M.D.</i>		22b. ADDRESS <i>1515 LAFAYETTE AVE.</i>	22c. DATE SIGNED <i>2-9-1959</i>
23a. BURIAL, CREMATION, REMOVAL <i>REMOVAL</i>	23b. DATE <i>2/12/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>ST PAUL CHURCHYARD</i>	23d. LOCATION (City, town, or county) (State) <i>ST LOUIS COUNTY MO.</i>

24. FUNERAL DIRECTOR <i>J L ZIEGENHEIN & SONS</i>	ADDRESS <i>7027 GRAVOIS</i>	25. DATE RECD. BY LOCAL REG. <i>FEB 12 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith. M.D.</i>
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m. 2. 03.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *A.P. Kiehl*

Licensed Embalmer No. *3877*
P. O. Address *7027*

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.