FILED MAY 15 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015878
STATE FILE NUMBER 2 4056

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Deaconess Hosp. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Webster Groves — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 204 Park Rd. — Reside on Farm Yes ☐ No ☐

4587

3. NAME OF DECEASED (Type or print): First ALBERT Middle FERDINAND Last VERSEN

4. DATE OF DEATH: Month April Day 23 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 26, 1875
9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months 3 Days 27 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secy
10b. KIND OF BUSINESS OR INDUSTRY: Local Meat Packers
11. BIRTHPLACE (City and state or country): Marine, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: August Versen
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 488-12-3362
17. INFORMANT: Lina E. Versen Address: 204 Park Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute brain Syndrome, [illegible] — INTERVAL BETWEEN ONSET AND DEATH: 1 week
Hypertension — 10 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclerosis — 10 years
DUE TO (c): 334 H
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of prostate -- Over 5 years
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year -----
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Nov. 1951 to Apr. 23, 1959 and last saw him alive on Apr. 23, 1959
Death occurred at 10:55 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [signature] (Degree or title) M.D.
22b. ADDRESS: 19 E. Lockwood, Webster Groves
22c. DATE SIGNED: 4/23/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Apr. 25, 1959
23c. NAME OF CEMETERY OR CREMATORY: Oak Grove Mausoleum
23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri

24. FUNERAL DIRECTOR ADDRESS: Ambruster Mortuary, 6633 Clayton Rd.
25. DATE REC'D BY LOCAL REG.: APR 25 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

(HT)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 4...

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.