

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **26798**
 Registrar's No. **2057**

FILED AUG 12 1952

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| BIRTH NO. | | REG. DIST. NO. 317 | | PRIMARY REG. DIST. NO. 500 | | Registrar's No. 2057 | |
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Affton | | | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Affton | | | |
| c. LENGTH OF STAY (in this place) unknown | | | | 4820 | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 9047 Coral Drive | | | | d. STREET ADDRESS (If rural, give location) 9047 Coral Drive | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Monika | | | b. (Middle) | | | c. (Last) Truetzschler | |
| 4. DATE OF DEATH (Month) (Day) (Year) July 31-1952 | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH May 3, 1858 | |
| 9. AGE (In years last birthday) 94 | | IF UNDER 1 YEAR Months | | IF UNDER 1 YEAR Days | | IF UNDER 2 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) Germany 4 | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13a. FATHER'S NAME Anton Streck | | | 13b. MOTHER'S MAIDEN NAME Elizabeth Dinger | | | 14. NAME OF HUSBAND OR WIFE August Truetzschler | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Pauline Meyer 9047 Coral Dr. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) * This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Coronary Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 6 yrs ANTECEDENT CAUSES 151X Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 151X DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS- Conditions contributing to the death but not related to the disease or condition causing death. Gen. Arterio Sclerosis 15 yr | | | |
| 19a. DATE OF OPERATION no | | 19b. MAJOR FINDINGS OF OPERATION no | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) no | | 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) no | | 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 June 1, 1952 , to 7-31, 1952 , that I last saw the deceased alive on 7-31, 1952 , and that death occurred at 4:45 pm. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) Walden W. Johnson M.D. | | | | 23b. ADDRESS 9505 Georgia | | 23c. DATE SIGNED 8-1-52 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 24b. DATE 7-31-52 | | 24c. NAME OF CEMETERY OR CREMATORY Mt. Olive | | 24d. LOCATION (City, town, or county) (State) Mt. Olive, Ill. | |
| DATE REC'D BY LOCAL REG. 8-1-52 | | | | REGISTRAR'S SIGNATURE Robert E. Donnell | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington | |

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
Student Embalmer

Signed John J. Harris
Licensed Embalmer No. 4108

P. O. Address Shawnee MO

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 this body is not embalmed, fact should be so stated above.