

FILED AUG 28 1948

Registration District No. 318

UNITED STATES DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 27857

Registrar's No. 7280

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri Baptist Hospital 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Elmer H. Janssen

3. (b) If veteran, name war World War #1 3. (c) Social Security No. P.O. Dept.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Gertrude 6. (c) Age of husband or wife if alive 500 years  
7. Birth date of deceased Aug. 13 1894  
(Month) (Day) (Year)

8. AGE: Years 54 Months 0 Days 4 If less than one day hr. min.

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business U.S. Post Office

12. Name Henry C. Janssen

13. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Emma Jost

15. Birthplace Columbia Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Gertrude Janssen

(b) Address 3424-Clara Ave-St. Louis, Mo.

17. (a) Burial (b) Date thereof 8-20-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Zion Cemetery

18. (a) Signature of funeral director Bartholomew Brodner

(b) Address 2504-Woodson Rd-Overland-11-Mo.

19. (a) AUG 19 1948 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3424-Clara Avenue  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 17  
year 1948 hour 9 minute 30 P.A.M.

21. I hereby certify that I attended the deceased from Aug 17 to Aug 17, 1948.  
that I last saw him alive on Aug 17, 1948.  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy Duration 1 day  
Hypertensive vascular disease

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 82

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 0

23. Signature H. F. Bergman (M. D. or other) M.D.  
Address 3720 Washington Date signed 8/19/48

MAY 3 1954

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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 3454

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address Overland 14, Ind

**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.**