

FILED APR 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10960
Registrar's No. 537

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3070

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Mo b. COUNTY St Louis 10	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN Webster Groves		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Webster Groves 19	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 311 So Old Orchard Ave	
d. FULL NAME OF HOSPITAL OR INSTITUTION 311 So Old Orchard Ave			

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) ERNST c. (Last) GIESMANN			4. DATE OF DEATH (Month) (Day) (Year) 3 5 1949		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6-10-1895	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 8 Days 5 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Herman Giesmann	13b. MOTHER'S MAIDEN NAME Henrietta Weiss	14. NAME OF HUSBAND OR WIFE Sophie Hennen Giesmann
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Max Soffin Giesmann ADDRESS Webster Groves 19 Mo
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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		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) End arteritis obliterans		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 456 X DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		99	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **1948 to Nov 5, 1949**, that I last saw the deceased alive on **Nov 5, 1949**, and that death occurred at **2-PM.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E. J. Volkmann	23b. ADDRESS West 12th St. Big Bend	23c. DATE SIGNED 3/7/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-8-49	24c. NAME OF CEMETERY OR CREMATORY ST PAULS CHURCHYARD	24d. LOCATION (City, town, or county) (State) AFFTON, ST. LOUIS CO. MO
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DATE REC'D BY LOCAL REG. 3-7-49	REGISTRAR'S SIGNATURE Thurmond Cunningham	25. FUNERAL DIRECTOR'S SIGNATURE Mittelberg Fun'l Home ADDRESS Webster Groves Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

..... Student Embalmer No.

working under my personal supervision.

Signed Albert G. Happe.....

Signed.....
Student Embalmer

Licensed Embalmer No. 2971

P. O. Address St. Louis 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.