

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED JUL 15 1949

State File No. 21104

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5813

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		b. COUNTY	
c. LENGTH OF STAY (In this place) 0		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL		d. STREET ADDRESS (If rural, give location) 3423 CAROLINE ST.	

3. NAME OF DECEASED (Type or Print) a. (First) JOHN	b. (Middle) HAILMAN	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) JULY 3 1949
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5. SEX M.	6. COLOR OR RACE W.	7. MARRIED-NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER	8. DATE OF BIRTH 2 APRIL 20 1879	9. AGE (In years last birthday) 71 YRS	10. UNDER 1 YEAR Months	11. UNDER 24 Hrs. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ST. LOUIS Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John HAILMAN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE MARGARET HAILMAN
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Arthur Cox	ADDRESS 3423 Caroline St
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage.</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>acute hypertension.</u>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 830
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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? 331X
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22. I hereby certify that I attended the deceased from 6-2-1949 to 7-3-1949, that I last saw the deceased alive on 7-3-1949, and that death occurred at 4:40 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John Alexander Mil	23b. ADDRESS 1504 So Grand Ave	23c. DATE SIGNED 7-5-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JULY 6-49	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo.
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DATE REC'D BY LOCAL REG. JUL 5 1949	REGISTRAR'S SIGNATURE J. B. Sarason	25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schmur	ADDRESS 3125 Lafayette Ave
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JUL 5 1949 (Licensed Embalmer's Statement on Reverse Side)

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.

Signed.....
Student Embalmer

Signed.....

Joseph B. Vollmer

Licensed Embalmer No. *4014*

P. O. Address *385 Lafayette St*

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.