

FILED JUN 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16343**

362
0

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

| | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------------------------|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>116</u> | | PRIMARY REG. DIST. NO. <u>3020</u> | | Registrar's No. <u>88</u> | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Franklin</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u> | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington</u> | | c. LENGTH OF STAY (In this place) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Union</u> | | 0360 | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u> | | | | d. STREET ADDRESS (If rural, give location) <u>R.R.</u> | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | a. (First) <u>August</u> | | | b. (Middle) <u>L. Hellmann</u> | | | |
| | | | c. (Last) | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>May 28 1950</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | | 8. DATE OF BIRTH <u>February 26 1897</u> | | 9. AGE (In years) (Months) (Days) (Hours) (Min.) | IF UNDER 1 YEAR | IF UNDER 10 HRS. | |
| | | <u>married</u> | | | | <u>53</u> | <u>3</u> | <u>2</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| <u>Carpenter</u> | | <u>washington mo</u> | | <u>washington mo</u> | | <u>U.S.A.</u> | | | |
| 13a. FATHER'S NAME <u>Arith Hellmann</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Annie Marguit</u> | | | 13c. NAME OF HUSBAND OR WIFE <u>Agness Hellmann</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>495-12-7941</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Agness Hellmann</u> | | | | ADDRESS <u>Union Mo.</u> | |
| <u>yes</u> | | <u>U. W. #1</u> | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Fracture of 2nd lumbar vertebra</u> | | | | | | <u>1 week</u> | |
| | | ANTECEDENT CAUSES | | | | | | | |
| | | Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | | | | |
| | | DUE TO (b) <u>Myocarditis, chr.</u> | | | | | | <u>3 years</u> | |
| | | DUE TO (c) <u>Cholelithiasis</u> | | | | | | <u>years</u> | |
| | | II. OTHER SIGNIFICANT CONDITIONS | | | | | | | |
| | | Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | <u>9.902</u> | |
| 19a. DATE OF OPERATION <u>none</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>036</u> | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT (Specify) <u>Accident</u> | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Dairy farm</u> | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Union Franklin Mo</u> | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>May 22 1950 10 AM</u> | | 21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Fell with scaffold</u> | | | | | |
| 22. I hereby certify that I attended the deceased from <u>May 22, 1950</u> , to <u>May 28, 1950</u> , that I last saw the deceased alive on <u>May 8, 1950</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Frank G. Mack M.D.</u> | | | | 23b. ADDRESS <u>3114 1/2th Washington Mo</u> | | | 23c. DATE SIGNED <u>5-29-50</u> | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>5/31/1950</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception</u> | | 24d. LOCATION (City, town, or county) (State) <u>Union Mo.</u> | | | |
| DATE REC'D BY LOCAL REG. <u>May 29 1950</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 990 | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>E. H. Oltmann</u> ADDRESS <u>Union Mo</u> | | | |

District File Number
District Health Officer No. 9,

RECEIVED
JUN 3 1950

JUN 11 1950

JUN 9 1950

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 E. F. Oltmann

Signed _____
Student Embalmer

Licensed Embalmer No. 1686

P. O. Address Union 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.