

FILED OCT 5 1950

THE DIVISION OF HEALTH - MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 31763  
Registrar's No. 8158

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> <u>Deaconess Hospital</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cooper</u>		
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>10 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Prairie Home</u> <u>0270</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Deaconess Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>Rural</u>		
3. NAME OF DECEASED (Type or Print) <u>Ottomer</u>			a. (First) <u>Ottomer</u>		b. (Middle) <u>L.</u>
			c. (Last) <u>Kirschman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 25 1950</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 17, 1890</u>		9. AGE (In years last birthday) <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (State or foreign country) <u>Prairie Home, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Ernest Kirschman</u>		13b. MOTHER'S MAIDEN NAME <u>Sophia Hofferbury</u>		14. NAME OF HUSBAND OR WIFE <u>Anna Kirschman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Tom Kirschman Prairie Home, Mo.</u>		
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* (a) <u>Brain Tumor</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>192X</u>			
22. I hereby certify that I attended the deceased from <u>9/15</u> , 19 <u>50</u> , to <u>9/25</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>9/25</u> , 19 <u>50</u> , and that death occurred at <u>1:35 P. m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>G. H. D. Hoppe M.D.</u>			23b. ADDRESS <u>University Club Bldg</u>		23c. DATE SIGNED <u>9/28/50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>9/26/1950</u>	24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>Prairie Home, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>SEP 27 1950</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe 4700 Washington</u>	

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

099171 190

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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 me

.....  
working under my personal supervision.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed *[Signature]*  
.....  
Licensed Embalmer No. 4699

P. O. Address St. Charles, 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.