

FILED NOV 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34903

State File No.

1003

9133

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY	
b. CITY OR TOWN <u>St Louis</u>	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <u>St. Louis</u> <u>2239</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2349 MENARD (REAR)</u>		d. STREET ADDRESS (If rural, give location) <u>2349 MENARD REAR</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>MALVINA</u> b. (Middle) <u>D.</u> c. (Last) <u>HELLMANN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10-27-50</u>		
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED 1</u>	8. DATE OF BIRTH <u>5-12-1882</u>	9. AGE (In years last birthday) <u>68yr.</u>	10. MONTHS <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>STOLPE Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>CHARLES BOHE</u>	13b. MOTHER'S MAIDEN NAME <u>UNK. WANDERSEK</u>	14. NAME OF HUSBAND OR WIFE <u>OSCAR HELLMANN</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Oscar Hellmann 2349 Menard</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized Arterio-sclerosis</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 (c) <u>Cerebral embolus</u>		
	11. 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 checked="" 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>322K</u>

22. I hereby certify that I attended the deceased from 10-27, 1950, to 10-27, 1950, that I last saw the deceased alive on 10-19, 1950, and that death occurred at 6:36a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. E. E. Egle, M.D.</u> (Degree or title)		23b. ADDRESS <u>634 No. Grand</u>	23c. DATE SIGNED <u>10-27-50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>10-30-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>NEW ST. MARCUS</u>	24d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>
DATE REC'D BY LOCAL REG. <u>Oct 27 1950</u>	REGISTRAR'S SIGNATURE <u>J. B. Jasater</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>E. J. Schum 3125 Lafayette</u>	

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.....

.....
working under my personal supervision.

Student Embalmer No.

Signed.....

Joe B. Vollmer

Signed.....
Student Embalmer

Licensed Embalmer No. *4014*

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.