

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

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **2520**

1. PLACE OF DEATH a. COUNTY St. Louis County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Carsonville, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Carsonville 4190	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 8842 Natural Bridge Ave.		d. STREET ADDRESS (If rural, give location) 8842 Natural Bridge Rd.	
3. NAME OF DECEASED (Type or Print) John F. Hartmann		4. DATE OF DEATH (Month) (Day) (Year) Oct. 16th, 1950	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 8th, 1868
9. AGE (In years last birthday) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Germany 4
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Katherin Kaul Hartmann	
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. No	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Katherin Hartmann		ADDRESS 8842 Natural Bridge	
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) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cardiac Decompensation	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) no	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? none		22. I hereby certify that I attended the deceased from July, 1950 , to 10-16, 1950 , that I last saw the deceased alive on 10-16, 1950 , and that death occurred at 9:30 P.m. , from the causes and on the date stated above.	
23a. SIGNATURE W. Stehlee (Degree or title) M.D.		23b. ADDRESS 7124 Natural Bridge	
23c. DATE SIGNED 10-17-50		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Oct. 19th, 1950		24c. NAME OF CEMETERY OR CREMATORY Memorial Park	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Kraeger-Voss, Inc. ADDRESS 3402 N. Kingshighway	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE OCT 18 1950		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	

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 Robert M. Murray

Signed.....
Student Embalmer

Licensed Embalmer No. 3749

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.