

FILED NOV 8 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35561  
9633

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2059	
d. FULL NAME OF HOSPITAL OR INSTITUTION 950 Belt Avenue		d. STREET ADDRESS (If rural, give location) 950 Belt Avenue	

3. NAME OF DECEASED (Type or Print) Fannie	a. (First)	b. (Middle)	c. (Last) Rottmann	4. DATE OF DEATH (Month) (Day) (Year) Oct. 30, 1951.
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 21, 1859	9. AGE (In years last birthday) 92	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Kerehner	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Miss. Pauline B. Rottmann, 950 Belt Ave.	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Hypertensive Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Indefinite</i>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <i>Arteriosclerosis</i>		
	DUE TO (b)		
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 checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>442X</i>
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22. I hereby certify that I attended the deceased from *6/22*, 1951, to *10/30*, 1951, that I last saw the deceased alive on *10-27*, 1951, and that death occurred at *10:15A* m., from the causes and on the date stated above.

23a. SIGNATURE <i>Pauline B. Rottmann M.D.</i> (Degree or title)	23b. ADDRESS <i>3601 Canina Dr. St. Louis 20 Mo.</i>	23c. DATE SIGNED <i>10/31-51</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>11/2/1951</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	24d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>
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DATE REC'D. BY, LOCAL REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Math Hermann &amp; Son Inc.</i>	ADDRESS <i>2161 E. Fair Ave.</i>
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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 .....  
Student Embalmer

Signed \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.