

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22898

FILED JUL 15 1953

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State File No. 5859

BIRTH NO. 39153 REG. DIST. NO. 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 Missouri b. COUNTY Saint Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 4810	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) 7124 Circleview Drive	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess			

3. NAME OF DECEASED (Type or Print) a. (First) Margaret b. (Middle) Mary c. (Last) Hollnagel			4. DATE OF DEATH (Month) (Day) (Year) June 11 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH June 11, 1953	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 10 Days 18
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) Missouri	
13a. FATHER'S NAME Harold E. Hollnagel			13b. MOTHER'S MAIDEN NAME Catherine Dabler		14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Harold E. Hollnagel	
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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION			

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity		ONSET AND DEATH 29 weeks gestation	
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.		Congenital Atelectosis 1 day	

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) 7625

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?
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22. I hereby certify that I attended the deceased from June 11, 1953, to June 11, 1953, that I last saw the deceased alive on June 11, 1953, and that death occurred at 11:25 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Francis D. Weibel M.D.	23b. ADDRESS 5203 Chippewa St. St. Louis, Mo.	23c. DATE SIGNED June 12 1953
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE June 12, 1953	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		

DATE REC'D BY LOCAL REG. JUN 12 1953	REGISTRAR'S SIGNATURE J. Culbertson	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS B. Hoffmeister Colonial Mortuary 6464 Chippewa St., St. Louis, Mo.
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____

Not embalmed
Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.