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0.48

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. **40613**

FILED DEC 4-1953

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **11034**

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 11034			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis				c. LENGTH OF STAY (In this place) 41 Years		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital				d. STREET ADDRESS (If rural, give location) 3924a Lee Avenue, 15,					
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH						
a. (First) EMILY			b. (Middle) ANN			c. (Last) HOLTMANN			
5. SEX Female			6. COLOR OR RACE White			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married			
8. DATE OF BIRTH Nov. 7th, 1897			9. AGE (In years last birthday) 56		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (State or foreign country) New Athens, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William Vonderheid			13b. MOTHER'S MAIDEN NAME Catherine Ballheimer			14. NAME OF HUSBAND OR WIFE Walter Holtmann			
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. None			17. INFORMANT'S SIGNATURE OR NAME Mr. Walter Holtmann, 3924a Lee Avenue, 7,			
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, asthenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic of lung						
			ANTECEDENT CAUSES						
			DUE TO (b) Gastric & duodenal Hemorrhage						
			DUE TO (c) Paroxysms of asphyxia						
			II. OTHER SIGNIFICANT CONDITIONS						
			Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION 11-12-53			19b. MAJOR FINDINGS OF OPERATION Chronic of lung; asphyxial paroxysms					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) (Minute)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 5810				
22. I hereby certify that I attended the deceased from 1-20, 1952 to 11-19, 1953 , that I last saw the deceased alive on 11-19, 1953 , and that death occurred at 8:55P m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) W. E. Muller, M.D.				23b. ADDRESS 4110 W. F. Lambert			23c. DATE SIGNED 11-10-53		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11/23/53		24c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri			
DATE REC'D BY LOCAL REG. NOV 20 1953		REGISTRAR'S SIGNATURE Carl Smith			25. FUNERAL DIRECTOR'S SIGNATURE CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., St. Louis, 15, Mo.				
FURNERAL HOME, INC.									

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

(Licensed Embalmer's Statement on Reverse Side)

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.....
Student Embalmer

Signed..... *Ralph C. Linder*

Licensed Embalmer No. *4275*

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.