

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6540

State File No. _____

BIRTH NO. _____ FILED MAR 4 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1001

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 <u>St. Louis</u>		a. STATE <u>Missouri</u>	b. COUNTY <u>2267</u>
c. LENGTH OF STAY (in this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DePaul Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>26 2107a N. 13th St.</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>Louisa</u>	b. (Middle) <u>Philippina</u>	c. (Last) <u>Maschmeier</u>	Feb. 1		1954
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>June 26, 1889</u>	9. AGE (in years last birthday) <u>64</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>
11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		

13a. FATHER'S NAME <u>J. Fred Maschmeier</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Frank Dohrmann</u>	ADDRESS <u>2107a N. 13th St.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cirrhosis of Liver</u>		DUE TO (b) _____		<u>Chronic</u>
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____		
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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>5810</u>
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22. I hereby certify that I attended the deceased from Dec 16, 1953 to Feb 1, 1954, that I last saw the deceased alive on Feb 1, 1954, and that death occurred at 3:30A m., from the causes and on the date stated above.

23a. SIGNATURE <u>M. Reichert M.D.</u> (Degree or title)	23b. ADDRESS <u>DePaul Hospital</u>	23c. DATE SIGNED <u>2/1/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Feb. 4 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>FEB 1 1954</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Calvin F. Feutz</u>	ADDRESS <u>4828 Natural Bridge Blvd.</u>
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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

John A. Melnar

Licensed Embalmer No. *4186*

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.