

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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11276

FILED APR 6 - 1956

State File No. ....

318

1003

3250

|   |                               |  |   |   |  |   |  |                                  |  |  |  |               |
|---|-------------------------------|--|---|---|--|---|--|----------------------------------|--|--|--|---------------|
| BIRTH NO. _____   |                               | REG. DIST. NO. _____   |   | PRIMARY REG. DIST. NO. <u>1003</u>  |  | Registrar's No. <u>3250</u>   |  |                                  |  |  |  |               |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |                               |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u><br>b. COUNTY _____ |  |   |  |                                  |  |  |  |               |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>   |                               | c. LENGTH OF STAY (In this place) <u>U.S.A.</u>  |   | c. CITY OR TOWN <u>St. Louis</u>  |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |                                  |  |  |  |               |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Louis State Hospital</u>  |                               |  |   | e. STREET ADDRESS (If rural, give location) <u>5100 Arsenal Street</u>  |  |   |  |                                  |  |  |  |               |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>Ethel</u>  |                               |  | b. (Middle) _____                                       |   | c. (Last) <u>Praul</u>   |   | 4. DATE OF DEATH (Month) (Day) (Year) <u>3-30-56</u> |                                  |  |  |  |               |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>                                   | 8. DATE OF BIRTH <u>Sept. 1, 1896</u>                   |   | 9. AGE (In years last birthday) <u>59</u>                                | IF UNDER 1 YEAR Months _____ Days _____   | IF UNDER 1 HR. Hours _____ Min. _____                |                                  |  |  |  |               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployable</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY _____  |   | 11. BIRTHPLACE (City and State or Foreign Country) <u>? Illinois</u>  |  | 12. CITIZEN OF WHAT COUNTRY? _____  |  |                                  |  |  |  |               |
| 13a. FATHER'S NAME <u>Randolph Praul</u>  |                               |  | 13b. MOTHER'S MAIDEN NAME <u>Myrtle Bashore Walston</u> |   | 14. NAME OF HUSBAND OR WIFE <u>None</u>                                  |   |  |                                  |  |  |  |               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>None</u>  |   | 17. INFORMANT'S SIGNATURE OR NAME <u>Linnie Atkins</u> ADDRESS <u>8016 Albin</u>  |  |   |  |                                  |  |  |  |               |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)   |                               |  |   | MEDICAL CERTIFICATION   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH |  |  |  |               |
| <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hodgkins Disease</u></p> <p>ANTECEDENT CAUSES</p> <p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p> <p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b) _____</p> <p>DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS</p> <p>Conditions contributing to the death but not related to the disease or condition causing death. <u>A.S.H.D.</u></p> |                               |  |   |   |  |   |  | <u>2 yrs.</u>                    |  |  |  |               |
|   |                               |  |   |   |  |   |  |                                  |  |  |  | <u>4 yrs.</u> |
|   |                               |  |   |   |  |   |  |                                  |  |  |  |               |
| 19a. DATE OF OPERATION _____  |                               | 19b. MAJOR FINDINGS OF OPERATION <u>201x</u>   |   |   |  | 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) (Min.) _____  |                               | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR? _____  |  |   |  |                                  |  |  |  |               |
| 22. I hereby certify that I attended the deceased from <u>Oct. 24, 1910</u> , to <u>March 30, 1956</u> , that I last saw the deceased alive on <u>March 30, 1956</u> , and that death occurred at <u>10:30 a.m.</u> , from the causes and on the date stated above.   |                               |  |   |   |  |   |  |                                  |  |  |  |               |
| 23a. SIGNATURE <u>E. Hoffstatter</u> (Degree or title) <u>M.D.</u>  |                               |  |   | 23b. ADDRESS <u>5100 Arsenal Street</u>   |  | 23c. DATE SIGNED <u>3-30-56</u>   |  |                                  |  |  |  |               |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>  |                               | 24b. DATE <u>Mar. 31, 1956</u>   | 24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>     |   | 24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u> |   |  |                                  |  |  |  |               |
| DATE REC'D BY LOCAL REG. <u>MAR 31 1956</u>   |                               | REGISTRAR'S SIGNATURE <u>J. Carl Smith - M.D.</u>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Ortmann Funeral Home</u> ADDRESS <u>9222 Lackland</u>   |  |   |  |                                  |  |  |  |               |

(Licensed Embalmer's Statement on Reverse Side)

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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.....  
Signature of Student Embalmer

Signed *Al C. Oetmann*.....

Licensed Embalmer No. *342*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.