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FILED AUG 24 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

285660

State File No. _____

6525

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 Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 1 day		d. STREET ADDRESS (If rural, give location) 23 1524 So. 12th., St.,	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hosp.,		3. NAME OF DECEASED a. (First) Nina b. (Middle) L c. (Last) Hittler	
4. DATE OF DEATH (Month) (Day) (Year) 7 11 '56		5. SEX F.	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 11-29-1914		9. AGE (In years last birthday) 41	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (City and State or Foreign Country) Van Buren Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Orby Chaffin		13b. MOTHER'S MAIDEN NAME Nora Green	
14. NAME OF HUSBAND OR WIFE Albert Hittler		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 Albert Hittler-1524 So. 12th., St.	

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) Cerebral Apoplexy		ANTECEDENT CAUSES			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **10:40 Am.**, from the causes and on the date stated above.

22a. SIGNATURE **Catrick E. Taylor, Coroner** (Degree or title) 22b. ADDRESS **1300 Clark** 22c. DATE SIGNED **7.12.56**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **7/14/56** 24c. NAME OF CEMETERY OR CREMATORY **SS Peter & Paul Cem** 24d. LOCATION (City, town, or county) (State) **St. Louis, Mo**

DATE REC'D BY LOCAL REG. **JUL 12 1956** REGISTRAR'S SIGNATURE **J. Carl Smith m.d.** 25. FUNERAL DIRECTOR'S SIGNATURE **MOYDELL FUNERAL HOME-1926 ALLEN AV** ADDRESS

S.P. (Licensed Embalmer's Statement on Reverse Side)

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 Reinhold K. Lohman

Licensed Embalmer No. 3395

P. O. Address St Louis Mo

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.