

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

289583

FILED SEP 6 1956

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar No. **7702**

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY - OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hosp. | | | Length of stay in lb | 11 d. STREET ADDRESS 3017 a Henrietta St. | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Betty Ann Pohlig | | | First | Middle | Last | 4. DATE OF DEATH 8/19/56 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12/6/24 | 9. AGE (In years last birthday) 31 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | | 10b. KIND OF BUSINESS OR INDUSTRY Medical R.N.. | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Alfred Pohlig | | | | 14. MOTHER'S MAIDEN NAME Emelia John | | | |
| 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. — | | 17. INFORMANT Mother Mrs. Emilia Pohlig 3017a Henrietta | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor (malignant) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs? |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | DUE TO (b) | | DUE TO (c) | | 193x |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE |
| 21. I attended the deceased from 8/16/56 to 8/17/56 and last saw her alive on 8/16/56 Death occurred at 6:20 A. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE G. E. Smith M.D. | | | (Degree or title) | 22b. ADDRESS Blouaine Med Bldg 8-20-56 | | | 22c. DATE SIGNED |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 8/22/56 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection | | 23d. LOCATION (City, town, or county) St. Louis Co., Mo. | | (State) |
| 24. FUNERAL DIRECTOR E. J. Schnur 3125 Lafayette Ave. | | | ADDRESS | 25. DATE RECD. BY LOCAL REG. AUG 20 1956 | | 26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. | |

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.....
Thomas R. Benwick

Licensed Embalmer No. *37*

P. O. Address *3125 Tap*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
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.