

FILED DEC 27 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

43154
11036BIRTH 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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3838a Utah		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
3. NAME OF DECEASED (Type or Print) Elizabeth Hartenbach		d. STREET ADDRESS (If rural, give location) 3838a Utah	
a. (First)		b. (Middle) 216	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Dec 1 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, <input type="radio"/> WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Jan 5 1872
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis Mo
13a. FATHER'S NAME Casper Hartenbach		13b. MOTHER'S MAIDEN NAME Miria Wellendick	14. NAME OF HUSBAND OR WIFE
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 ADDRESS Mrs. Estelle Baier 3838a Utah
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Fractures INTERVAL BETWEEN ONSET AND DEATH Suffered when deceased fell from window at home II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Dec 1st of December, exact time unknown, during epileptic seizure.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20. AUTOPSY	
21a. ACCIDENT, SUICIDE, HOLOCIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12 / 56 ?	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 6:50 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) St. Louis E. Taylor Carner		23b. ADDRESS 1300 Clark	23c. DATE SIGNED 12/3/56
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec 4 1956	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
DATE REC'D BY LOCAL REG. DEC 3 1956	REGISTRAR'S SIGNATURE Paul Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Weick Bros 2201 S. Grand Blvd	

(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

Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis 9, 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.