

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, or other person making this report must certify that the cause of death is natural, accidental, or homicidal. If the cause of death is natural, the coroner must also certify that the death was not due to any communicable disease. If the cause of death is accidental or homicidal, the coroner must also certify that the death was not due to any communicable disease. If the cause of death is natural, the coroner must also certify that the death was not due to any communicable disease. If the cause of death is accidental or homicidal, the coroner must also certify that the death was not due to any communicable disease.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAY 27 1957

18610

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4467

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, 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 Firman Desloge Hosp.			Length of stay in lb 3 wks.		d. STREET ADDRESS 5347 Cabanne Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Herman Drosten				4. DATE OF DEATH Month Day Year 5 8 57			
5. SEX Male <input type="radio"/>	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 14, 1875		9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker - Ret.			10b. KIND OF BUSINESS OR INDUSTRY Baking	11. BIRTHPLACE (City and state or country) Carlinville, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred W. Drosten				14. MOTHER'S MAIDEN NAME Julia Dohrs			
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 Address Mrs. Blanche Drosten, 5347 Cabanne			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 Diabetes mellitus 2 Grad. Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Uncertain</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>1517</u>					
20c. TIME OF INJURY Hour: _____ Month: _____ Day: _____ 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 <u>Jan 16, 1957</u> to <u>May 8, 1957</u> and last saw <sup>him</sup> alive on <u>May 5, 1957</u> Death occurred at <u>4:15</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Dr. Oppenheimer, MD</u>				22b. ADDRESS <u>35 N. Central Ave, Carter 5</u>		22c. DATE SIGNED <u>May 9, 1957</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE <u>5/11/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Drehmann-Harral 1905 Union</u>			25. DATE RECD. BY LOCAL REG. <u>MAY 10 '57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>		

(Licensed Embalmer's Statement on Reverse Side)

Dr. Henry E. Oppenheimer  
35 N. Central  
Pa. 5-9656

Hrs. 11 - 3  
1 - 5  
Thurs.  
Fri.

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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 em-  
by me, or by....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Warren A. Carver*.....

Licensed Embalmer No. *35*

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.