

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STANDARD CERTIFICATE OF DEATH

FILED JUL 22 1957

26974

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1255

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Franklin		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Valley Park		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Union		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cedarcroft Nursing Home		Length of stay in 1b 10 days	d. STREET ADDRESS (If outside, give location) Union Rest Home		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First August Middle F. Last Pohlig			4. DATE OF DEATH Month July Day 10 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1878	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Packing House Worker Meats		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or county) Fiddle Creek, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Julius Pohlig			14. MOTHER'S MAIDEN NAME Emilia Schueddig		
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. James S. Maher, 3754a. Keokuk St.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident					INTERVAL BETWEEN ONSET AND DEATH 1 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardiac Decompensation					
DUE TO (c) Arteriosclerotic Cardio-Vascular Disease					
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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" 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.) 4221		
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 July 4, 1957 to July 9, 1957 and last saw her alive on July 9, 1957 Death occurred at 9:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS DR. J. M. GOTTINGHAM P. O. BOX 248 VALLEY PARK, MO.		22c. DATE SIGNED July 12 57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE July 13, 1957	23c. NAME OF CEMETERY OR CREMATORY St. Matthew Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR ADDRESS BEIDERWIEDEN F.H., Inc. 1936 St. Louis Av.			25. DATE RECD. BY LOCAL REG. 7/12/57		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

DR. J. M. COTTINGHAM,
P. O. BOX 248
VALLEY PARK, MO.

Phone - Office Valley 5-2222
Res. 5-2250

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 Robert J. Kruse

Licensed Embalmer No. 3

P. O. Address St. Louis

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.