

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29091**

FILED AUG 26 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 203

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. CITY OR TOWN <u>St. Charles</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>5yrs.</u>		e. STREET ADDRESS (If rural, give location) <u>622 Washington St. 09230</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>622 Washington St.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Elmer</u> b. (Middle) <u>F.</u> c. (Last) <u>Hollrah</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 15, 1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 5, 1901</u>	9. AGE (In years last birthday) <u>55</u>	10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Charles, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Herman Hollrah</u>	13b. MOTHER'S MAIDEN NAME <u>Fredericka Diekmann</u>	14. NAME OF HUSBAND OR WIFE <u>Linda Kernkamp Hollrah</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>498-18-8169</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Linda Kernkamp Hollrah, Same</u>
--	--	--

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebrovascular of Brain</u>		
	ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Myeloma Eye.</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>			

19a. DATE OF OPERATION <u>1950</u>	19b. MAJOR FINDINGS OF OPERATION <u>Myeloma of eye - Enucleation - 192X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 May 1, 1957, to Aug 15, 1957, that I last saw the deceased alive on Aug 14, 1957 and that death occurred at 3:30 pm., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____	23b. ADDRESS <u>St Charles Mo Aug 12-57</u>	23c. DATE SIGNED _____
---	---	------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug. 19, 1957</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Charles, Missouri</u>
---	--------------------------------	---	--

DATE REC'D BY LOCAL REG. <u>Aug 18-57</u>	REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur C. Bane St Charles Mo.</u>
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

540  
0

AUG 27 1957

MAR 14 1958

**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 .....  
*Arthur C. Rose*

Licensed Embalmer No. .... *314*

P. O. Address .....  
*St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.