

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 29 1957

37328  
STATE FILE NUMBER  
9776

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN UNION	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 620 UNION AVE.	
3. NAME OF DECEASED (Type or print) First Middle Last EDNA CLARA DANZ		4. DATE OF DEATH OCT. 17, 1957	
5. SEX FEMALE	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 NOV. 6, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	9. AGE (In years at birthday) 50
13a. FATHER'S NAME EWALD WATERMANN		13b. MOTHER'S MAIDEN NAME BARBARA BOEHMER	11. BIRTHPLACE (City and state or country) WASHINGTON, MO.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	12. CITIZEN OF WHAT COUNTRY? U.S.A.
17. INFORMANT OSCAR H. DANZ		14. NAME OF HUSBAND OR WIFE OSCAR H. DANZ UNION, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYELOGENOUS LEUKEMIA			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
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 o.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from SEPT. 21, 1957 to OCTOBER 17, 1957 and last saw her alive on OCT. 17, 1957 Death occurred at 6:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>E. G. Olthoff, M.D.</i> M. D.		22b. ADDRESS BARNES HOSPITAL	
22c. DATE SIGNED 10-17-57			
23a. BURIAL, CREMATION, (Specify)	23b. DATE 10/21/57	23c. NAME OF CEMETERY OR CREMATORY IMMACULATE CONCEPTION UNION MO.	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR ADDRESS <i>E. G. Olthoff</i> UNION, MO.		25. DATE RECD. BY LOCAL REG. OCT 18 '57	26. REGISTRAR'S SIGNATURE <i>Earl Smith, MD</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *E. F. Olthmann* .....

Licensed Embalmer No. *1686* .....  
P. O. Address *Union, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.