

Health,
& Welfare
S. Public
Health Service

S. 300
v. 1-56

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.

FILED DEC 2 - 1957

STANDARD CERTIFICATE OF DEATH

318

1003

STATE FILE NUMBER 42045

Registration No. 11140

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY										
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>								
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE <u>1925 Allen Ave</u>			Length of stay in 1b		STREET ADDRESS (If outside, give location) <u>1925 Allen Ave</u>		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Aloysius</u> Middle <u>J.</u> Last <u>Handing</u>				4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1957</u>										
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-28-1906</u>		9. AGE (In years last birthday) <u>51</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Mgr.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Watson Bros.</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Louis Handing</u>						14. MOTHER'S MAIDEN NAME <u>Rorehr</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>---</u>		17. INFORMANT Address <u>Audrey Handing-1925 Allen Ave.</u>								
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>Uremia</u>										INTERVAL BETWEEN ONSET AND DEATH <u>14 years</u>				
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Hypertension and arteriosclerosis</u>		DUE TO (c) <u>331x</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>① Nephritis ② cerebral hemorrhage</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>				
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 a. m. p. m. Month, Day, Year														
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>16 May 1952</u> to <u>19 Nov 1957</u> and last saw ^{her} _{him} alive on <u>19 Nov 57</u> Death occurred at <u>10:30</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>Raymond Williams MD</u>						22b. ADDRESS <u>114 NOTAY/or. St. Louis</u>				22c. DATE SIGNED <u>20 Nov 57</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>			23b. DATE <u>11/22/1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>St. Louis County</u>						
24. FUNERAL DIRECTOR <u>MOYDELL FUNERAL HOME-1926 ALLEN AVE</u>					25. DATE RECD. BY LOCAL REG. <u>NOV 21 57</u>			26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>m JB</u>						

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Reinhold K. Lohrmann*

Licensed Embalmer No. *3395*

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.