

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JAN 14 1958

STANDARD CERTIFICATE OF DEATH

45541
STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 433

1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Scott					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Twp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN Benton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #4			Length of stay in 1b 30y, 8m, 17d		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First, VALENTINE Middle, UHRHAN Last, UHRHAN				4. DATE OF DEATH Month Dec. Day 30 Year 1957					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1902		9. AGE (In years last birthday) 55 IF UNDER 1 YEAR: Months 7 Days 7 Hours Min. IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Uhrhan				14. MOTHER'S MAIDEN NAME Rosa Glasser					
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 Records, State Hospital #4, Farmington, Mo.			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia, bilateral, - - - - -								INTERVAL BETWEEN ONSET AND DEATH 5 das.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Severe epileptic seizures - - - - -								5 das.	
DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Psychosis with epilepsy.								19. WAS AUTOPSY PERFORMED? 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.)						
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____									
20d. INJURY OCCURRED WHILE AT <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 Dec. 25, 1957 to Dec. 30, 1957 and last saw ^{her} him alive on Dec. 30, 1957 Death occurred at 3:25 P. M. m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>John A. Brennan, M.D.</i>				22b. ADDRESS State Hospital No. 4, Farmington, Missouri				22c. DATE SIGNED 12-30-57.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 2, 1958		23c. NAME OF CEMETERY OR CREMATORY St. Lawrence Cem.		23d. LOCATION (City, town, or county) (State) New Hamburg, Mo.			
24. FUNERAL DIRECTOR Earl J. Smith Funeral Home, Oran, Mo.				25. DATE RECD. BY LOCAL REG. Dec. 30, 1957		26. REGISTRAR'S SIGNATURE <i>Esther Rudloff</i>			

(Licensed Embalmer's Statement on Reverse Side)

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 *Paul J. Smith*

Licensed Embalmer No. 5019

P. O. Address Box # 1
Orem, UT

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.