

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3292

STATE FILE NUMBER

80

FILED FEB 14 1958

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)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Overland #23X
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital		Length of stay in 1b 3 WEEKS	d. STREET ADDRESS (If outside, give location) 27 9108 Arline
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) Harry Maschmeyer			4. DATE OF DEATH Month Day Year Jan. 3 1958		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1888		9. AGE (In years last birthday) 69
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired supervisor Machine Shop		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Henry Maschmeyer		13b. MOTHER'S MAIDEN NAME Unk.		14. NAME OF HUSBAND OR WIFE Kathryn Maschmeyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes		16. SOCIAL SECURITY NO. 490-03-2131		17. INFORMANT Kathryn Maschmeyer Address 9108 Arline	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of bladder with metastases to hip bone, liver & adrenal DUE TO (b) to hip bone, liver & adrenal DUE TO (c) _____ 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 5 yrs		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1810		

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. Month, Day, Year p.m.					

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 15 1957 to Jan 3, 1958 and last saw ^{her} him alive on Jan 3, 1958 Death occurred at 10 P.M. 10100 P. on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE Grayson Carroll (Degree or title) Grayson Carroll M.D.		22b. ADDRESS 316 Beaumont Bldg.		22c. DATE SIGNED Jan 4, 58	
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 6, 1958		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
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24. FUNERAL DIRECTOR Ortmann F. Home		ADDRESS 9222 Lackland Overland 14, Mo.		25. DATE RECD. BY LOCAL REG. JAN 6 '58		26. REGISTRAR'S SIGNATURE Earl Smith Mo mfb	
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

