

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3925

FILED JAN 27 1958

STATE FILE NUMBER

Registration District No. 317

Primary Registration District No. 546

Registrar's No. 104

1. PLACE OF DEATH a. COUNTY <i>St. Louis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> COUNTY <i>St. Louis</i>	
b. CITY OR TOWN <i>Overland</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Overland 4231</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Restorium</i>		d. STREET ADDRESS (If outside, give location) <i>10460 Thorpe</i>	

3. NAME OF DECEASED (Type or print) First <i>Ella</i> Middle <i>E.</i> Last <i>Gortmann</i>			4. DATE OF DEATH Month <i>July</i> Day <i>10</i> Year <i>1958</i>		
--	--	--	--	--	--

5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 2, 1976</i>	9. AGE (In years last birthday) <i>81</i>	IF UNDER 1 YEAR Months <i>10</i> Days <i>8</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
----------------------	-------------------------------	---	---------------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (City and state or country) <i>Alexandria Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
--	--	---	--

13a. FATHER'S NAME <i>William S. Watkins</i>	13b. MOTHER'S MAIDEN NAME <i>Mollie Rogers</i>	14. NAME OF HUSBAND OR WIFE <i>John A. Gortmann</i>
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>David L. Brub</i> Address <i>722 Chestnut</i>
---	-------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>
---	--	---

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) \_\_\_\_\_

DUE TO (c) *493X*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
*Atherosclerotic Heart Disease with auricular fibrillation*

19. WAS AUTOPSY PERFORMED? YES  NO

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.	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 <i>Sept 30, 1957</i> to <i>Jan 10, 1958</i> and last saw her alive on <i>Jan 9, 1958</i> Death occurred at <i>11:30</i> A.M. on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE <i>Rosa B. Sommer M.D.</i> (Degree or title)	22b. ADDRESS <i>100 N. Euclid, St. Louis</i>	22c. DATE SIGNED <i>1/11/58</i>
---	--	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>July 13, 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Valhalla Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Charles Rock Road Mo.</i>
---	--------------------------------	---	--

24. FUNERAL DIRECTOR <i>Bull Campbell Mortuary</i> ADDRESS <i>5165 Aldridge</i>	25. DATE RECD. BY LOCAL REG. <i>1-13-58</i>	26. REGISTRAR'S SIGNATURE <i>Herbert A. Lombard</i>
---	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

390  
157  
4

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with which deceased in Part I must be causally related.

89

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  .....

Licensed Embalmer No. 4108 .....

P. O. Address St. Louis, 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.