

Health,  
Welfare  
Public  
Service

300  
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 causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4005

FILED JAN 30 1958

STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 500 Registrar's No. 82

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS KOCH</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" 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 INSTITUTION <u>ROBERT KOCH HOSP.</u>			Length of stay in 1b <u>148 days</u>		d. STREET ADDRESS <u>5800 ARSENAL</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>JANNETTE</u> First <u>HAMLYN</u> Last				4. DATE OF DEATH <u>1</u> <u>9</u> <u>58</u> Month Day Year					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1 - 26 - 74</u>		9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13. FATHER'S NAME <u>JOHN JAMES SMITH</u>				14. MOTHER'S MAIDEN NAME <u>AMY SMITH</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>NONE</u>		17. INFORMANT <u>ROBERT KOCH RECORD ROOM, KOCH, MO.</u> 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) <u>Confluent Broncho Pneumonia</u>								INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. DUE TO (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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>8-14-57</u> to <u>1-9-58</u> and last saw her alive on <u>1-8-58</u> Death occurred at <u>6:15</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>Axel R. Loman, M.D.</u>						22b. ADDRESS <u>Koch, Missouri,</u>		22c. DATE SIGNED <u>1/9/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial,</u>		23b. DATE <u>1/13/58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery,</u>		23d. LOCATION (City, town, or county) <u>Lemay, Missouri,</u>		(State)	
24. FUNERAL DIRECTOR <u>Gebken-Benz Mortuary,</u> ADDRESS <u>2842 Meramec St., St. Louis, 18, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Jan 10, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Donk</u>			

(Licensed Embalmer's Statement on Reverse Side)

arc

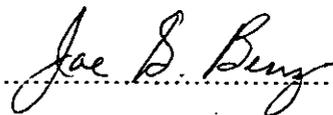
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... <sup>me</sup> ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....



Licensed Embalmer No. 4249

2842 Meramec

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.