

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015456

STATE FILE NUMBER

FILED MAY 13 1958

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 174

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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jefferson</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>St. Francois Twp.</u> TOWN		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR <u>De Soto</u> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #4</u>			Length of stay in lb <u>28y, 6m, 24d</u>		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) <u>LUCILLE</u>				First <u>Middle</u> Last <u>MAHN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Female</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>Jan. 2, 1893</u>		9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Month <u>3</u> Days <u>15</u>	IF UNDER 24 HRS. Hour <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory work</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Jacob Mahn</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Hentcher</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 Address <u>Records, State Hospital #4, Farmington, Mo.</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>Inanition</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 das.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Dementia Praecox Psychosis - - - - -</u>							Abt. <u>30 yrs.</u>		
DUE TO (c) <u>3007A</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bilateral Pulmonary tuberculosis as revealed by x-ray, 5-18-49.</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 <u></u> Month, Day, Year a. m. <u></u> p. m. <u></u>									
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>April 15, 1958</u> to <u>April 17, 1958</u> and last saw her <sup>her FROM</sup> alive on <u>April 17, 1958</u> Death occurred at <u>12:08 A. M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>John L. Brenner, M.D.</u> (Degree or title)				22b. ADDRESS <u>State Hospital No. 4</u> <u>Farmington, Missouri</u>			22c. DATE SIGNED <u>4-17-58</u>		
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)		23b. DATE <u>4/19/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		23d. LOCATION (City, town, or county) <u>De Soto</u>		(State) <u>Mo.</u>		
24. FUNERAL DIRECTOR <u>MAHN Funeral Home</u>			ADDRESS <u>De Soto, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Apr. 17, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>		

(Licensed Embalmer's Statement on Reverse Side)

MAY 13 1958

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 *Araldo J. Mohr*

Licensed Embalmer No. *491*

P. O. Address *De Soto*

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.