

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016794
STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1047

Health,
Welfare
Public
Service

4005
300
1-56

ALL diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bellefontaine Neighbors</u>		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>St. Mary's Hospital</u>			Length of stay in lb <u>24-days</u>	d. STREET ADDRESS (If outside, give location) <u>1212 Longridge</u>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>E.</u> Last <u>Littmann</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1958</u>				
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</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>Feb. 3, 1901</u>		9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Agt. Endicott-Johnson Shoe Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Louis, Missouri</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Julius Littmann</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Mahoney</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>489-07-4854</u>		17. INFORMANT <u>Mrs. Raymond E. Littmann, 1212 Longridge</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>Cerebral Hemorrhage</u> DUE TO (b) <u>Post-operative shock & embolus</u> DUE TO (c) <u>atelectasis of lungs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>159K</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</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.) <u>159K</u>					
20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> 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.) <u> </u>	
20f. CITY, TOWN, OR LOCATION <u> </u>			COUNTY <u> </u>		STATE <u> </u>			
21. I attended the deceased from <u>3/29</u> , to <u>4/14/58</u> and last saw him alive on <u>4/10/58</u> . Death occurred at <u> </u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Dr. Fessenden M.D.</u> (Degree or title)				22b. ADDRESS <u>7307 Natural Bridge</u>		22c. DATE SIGNED <u>4/14/58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>April 16, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Mausoleum</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>			
24. FUNERAL DIRECTOR <u>Arthur J. Donnell</u> ADDRESS <u>3840 Lindell Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>4-15-58</u>		26. REGISTRAR'S SIGNATURE <u>Walter R. Donke M.D.</u>		

(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 *Wm S. Saylor*
.....

Licensed Embalmer No. *461*

P. O. Address *3840*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.