

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041146

STATE FILE NUMBER

FILED NOV 24 1958

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 264

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1-57

1. PLACE OF DEATH a. COUNTY <b>ST. CHARLES</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. CHARLES</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. CHARLES</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. CHARLES</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>JEFFERSON ST. NURS. H. L. Wk.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>733 MADISON ST.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ALVINA</b> Middle <b>L.</b> Last <b>HOLLRAH</b>			4. DATE OF DEATH Month <b>NOV.</b> Day <b>12</b> Year <b>1958</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 20, 1887</b>	9. AGE (In years, last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEKEEPER</b>	11. BIRTHPLACE (City and state or country) <b>ST. CHARLES COUNTY MO USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>HERMAN C. ERMELING</b>		13b. MOTHER'S MAIDEN NAME <b>MARGARET THEOLE</b>		14. NAME OF HUSBAND OR WIFE <b>EDWIN H. HOLLRAH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>EDWIN H. HOLLRAH</b> Address <b>ST. CHARLES, MO.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Mural Thrombus of Heart</b>					<b>1 1/2 yrs.</b>
DUE TO (c) <b>Myocardial Infarction</b>					<b>1 1/2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4201</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <b>1/23/56</b> to <b>11/12/58</b> and last saw her alive on <b>11/12/58</b> Death occurred at <b>10:30</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Paul H. Lotter MD</i> (Degree or title)			22b. ADDRESS <b>114 N. Main St. St. Charles, Mo.</b>		22c. DATE SIGNED <b>11/15/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>NOV. 15, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LUTHERAN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>ST. CHARLES, MO.</b>	
24. FUNERAL DIRECTOR <b>ARTHUR C BAUE, ST. CHARLES, MO.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Nov 15 1958</b>	26. REGISTRAR'S SIGNATURE <i>Marcella Wilson</i>	

(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.

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 *David C. Baue* .....

Licensed Embalmer No. *5060* .....

P. O. Address *St. Charles,* .....

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.