

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041711

STATE FILE NUMBER

11053

FILED DEC 1 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1		Length of stay in lb	d. STREET ADDRESS St. Francis Hotel 60 1/2 Chestnut

3. NAME OF DECEASED (Type or print) First Middle Last John Holtman			4. DATE OF DEATH Month Day Year 11 14 58		
--	--	--	--	--	--

5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-1887	9. AGE (In years last birthday) 71	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) Gardener	10b. KIND OF BUSINESS OR INDUSTRY Nurse	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	--	--	--

13a. FATHER'S NAME Christopher Holtman	13b. MOTHER'S MAIDEN NAME Nellie (Unknown)	14. NAME OF HUSBAND OR WIFE Nil.
---	---	-------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. 487-26-0146	17. INFORMANT Agnes Holtman, 3520 Chippewa, Ave.
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALNUTRITION		INTERVAL BETWEEN ONSET AND DEATH 8 WEEKS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) SQUAMOUS CELL CARCINOMA OF ESOPHAGUS	18 MONTHS
	DUE TO (c) 150X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	---

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 11-11-58 to 11-14-58 and last saw him alive on 11-14-58 Death occurred at 7:15P. m on the date stated above; and to the best of my knowledge, from the causes stated.		
---	--	--

22a. SIGNATURE John Allen Burrell (M.D.)	22b. ADDRESS 1515 Lafayette Ave.	22c. DATE SIGNED 11-17-58
---	-------------------------------------	------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-17-58	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
--	-----------------------	--	--

24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. NW 1758	26. REGISTRAR'S SIGNATURE Carl Smith MD
--	---	--

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 *Melvin L. Kempner*

Licensed Embalmer No. *4053*
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.