

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003058
STATE FILE NUMBER
2
768
Registrar's No.

FILED FEB 10 1959

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo.		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		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital		Length of stay in 1b 1 day		d. STREET ADDRESS (If outside, give location) 2079 ADDRESS 4550 Arlington		
3. NAME OF DECEASED (Type or print) First Middle Last ELMER L. HERMAN			4. DATE OF DEATH Month Day Year Jan. 22 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23 1907	9. AGE (In years last birthday) 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cheauffer		10b. KIND OF BUSINESS OR INDUSTRY Triangle Exp.	11. BIRTHPLACE (City and state or country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Frank Herman		13b. MOTHER'S MAIDEN NAME Henrietta Peska		14. NAME OF HUSBAND OR WIFE Eleanor Herman		
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. 493 01 1907	17. INFORMANT Address Eleanor Herman 4550 Arlington 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) Anterior & Posterior Myocardial Infarct. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) 420.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, city, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from 1/20/59 to 1/29/59 and last saw him alive on 1/29/59. Death occurred at 10:32 m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE Carl Smith, M.D. (Degree or title)			22b. ADDRESS 10093 W Florissant		22c. DATE SIGNED 1/23/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 1/26/59	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens		23d. LOCATION (City, town, or county) St. Louis County	(State) Mo.	
24. FUNERAL DIRECTOR Buchholz Mortuary 5967 W. Florissant		ADDRESS	25. DATE RECD. BY LOCAL REG. JAN 23 '59	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		

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 *Walter W. Buckley*

Licensed Embalmer No. *4551*

P. O. Address: *St. Louis*

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.