Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003270
STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 759

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jefferson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST.LOUIS,MO. Inside Limits Yes ☐ No ☐	c. CITY OR TOWN 0500 Imperial St. Louis Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST.LOUIS CITY HOSP. #1. Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Rte. 3 Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First HERMAN · F. J. Middle MAUNE Last		4. DATE OF DEATH Month JAN. Day 21, Year 1959	
5. SEX M 0	6. COLOR OR RACE W	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐	8. DATE OF BIRTH 6/28/1877
9. AGE (In years last birthday) 81	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) Ret. Grocer	10b. KIND OF BUSINESS OR INDUSTRY own	11. BIRTHPLACE (City and state or country) St. Louis Mo. 0	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Henry	13b. MOTHER'S MAIDEN NAME Mary Willmann	14. NAME OF HUSBAND OR WIFE Caroline (deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 494-05-1416A	17. INFORMANT Mat Blase Rte 3 Address Imperial Mo.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: Encephalomalacia

IMMEDIATE CAUSE (a) Pulmonary edema

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 332X

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

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 ☒ NO ☐ 1

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 11/20/58, to 1/21/59 and last saw her/him alive on 1/21/59

Death occurred at 7:35 A.M m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] M.D. 0	22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 1/21/59
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 1/23/59	23c. NAME OF CEMETERY OR CREMATORY Memorial Park
23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		
24. FUNERAL DIRECTOR ADDRESS Schumacher 3013 Meramec	25. DATE RECD. BY LOCAL REG. JAN 23 '59	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. M.J.B.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Jack Haupt

Licensed Embalmer No. 4746

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.