Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003839
STATE FILE NUMBER

FILED FEB 11 1959 Registration District No. 317 Primary Registration District No. 546 Registrar's No. 232

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Overland — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 2708 Wismer — Length of stay in 1b 3 Yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Overland 423X — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 2708 Wismer — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Rosa Middle: L. Last: Hahn

4. DATE OF DEATH Month Day Year: Jan. 22nd 1959

5. SEX: Female 6. COLOR OR RACE: White 7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: July 12th 1872

9. AGE (In years last birthday): 86 — 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): Owner
10b. KIND OF BUSINESS OR INDUSTRY: Confectionery
11. BIRTHPLACE (City and state or country): Switzerland
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Anthony Kaellen
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Joseph Hahn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO. 490-38-5258 A
17. INFORMANT: Mary Stege Address: Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 1-22 / 1-22
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

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 Oct 11, 1957, to Jan 21, 1959 and last saw her/him alive on Jan 22, 1959
Death occurred at 1:45 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE S Stawol, M.D. (Degree or title)
22b. ADDRESS 2573 Woodson Rd. Overland Mo.
22c. DATE SIGNED 1-23-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1-26-59
23c. NAME OF CEMETERY OR CREMATORY: Calvary
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS: JAY B. SMITH, Maplewood, Mo.
25. DATE RECD. BY LOCAL REG. 1-24-59
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.