

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007191

STATE FILE NUMBER

2 1584

FILED MAR 2 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300
-57

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|--|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1.</u> | | Length of stay in lb <u>#1.</u> | d. STREET ADDRESS (If outside, give location) <u>2919 N. Vandeventer</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD JOHN HARTMANN</u> | | | 4. DATE OF DEATH Month Day Year <u>FEB. 13, 1959</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 19, 1902</u> | 9. AGE (In years last birthday) <u>56</u> | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Florissant, Mo.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>John Hartmann</u> | | 13b. MOTHER'S MAIDEN NAME <u>Margaret Meyer</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Adele</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Adele Hartmann</u> | | Address <u>2919 N. Vandeventer</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Jaenno's Periosis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>week</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <u>581.1</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>pneumococcal peritonitis</u> | | | | | 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. | | | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>2/11/59</u> to <u>2/13/59</u> and last saw her/him alive on <u>2/13/59</u> Death occurred at <u>11:50 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>Earl A. Chofman, M.D.</u> (Degree or title) | | | | 22b. ADDRESS <u>1515 LAFAYETTE AVE</u> | |
| | | | | 22c. DATE SIGNED <u>2/13/59</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 23b. DATE <u>2-16-59</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | |
| | | | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u> | |
| 24. FUNERAL DIRECTOR <u>Hy. Leidner Und. Co.</u> | | | ADDRESS <u>2223 St. Louis Ave.</u> | | 25. DATE RECD. BY LOCAL REG. <u>FEB 14 '59</u> |
| | | | 26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> | | |

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 *Wil Mayfield*

Licensed Embalmer No. *3077*
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.