Health, Welfare Public Service

FILED FEB 17 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007324
STATE FILE NUMBER

SL14875 Registration District No. ____ Primary Registration District No. ____ Registrar's No. 2 1210

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before) a. STATE MISSOURI b. COUNTY STE FRANCOIS
b. CITY OR TOWN ST. LOUIS, MISSOURI — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN FARMINGTON 0741 — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) VAH, 915 N GRAND AVE — Length of stay in Ib 18 DAYS	d. STREET ADDRESS (If outside, give location) 309 HICKORY — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: MELVIN	Middle: C.	Last: KOLLMEYER	4. DATE OF DEATH Month Day Year: FEBRUARY 3, 1959	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: 4/24/29	9. AGE (In years last birthday): 29 — 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): TECH WRITER	10b. KIND OF BUSINESS OR INDUSTRY: —	11. BIRTHPLACE (City and state or country): FARMINGTON, MISSOURI	12. CITIZEN OF WHAT COUNTRY?: USA	
13a. FATHER'S NAME: FRANK KOLLMEYER	13b. MOTHER'S MAIDEN NAME: WILLA GRIFFIN	14. NAME OF HUSBAND OR WIFE: BETTY KOLLMEYER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): KOREAN	16. SOCIAL SECURITY NO.: 488-34-5076	17. INFORMANT: VAH, 915 N GRAND AVE., ST. LOUIS, MO.	Address	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) HODGKINS DISEASE

DUE TO (c) 201x

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 [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ] NONE

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/VA attended the deceased from 1/16/59, to 2/3/59 and last saw him alive on 2/3/59

Death occurred at 10:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: ROBERT E. BAKER (Degree or title): M.D.	22b. ADDRESS: VAH, ST. LOUIS, MO.	22c. DATE SIGNED: 2/3/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 2-5-59	23c. NAME OF CEMETERY OR CREMATORY: St. Pauls Luth. Cemetery	23d. LOCATION (City, town, or county) (State): Farmington, Mo
24. FUNERAL DIRECTOR ADDRESS: Miller Funeral Home, Farmington, Mo.	25. DATE RECD. BY LOCAL REG.: FEB 3 '59	26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.	

(Licensed Embalmer's Statement on Reverse Side)

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.