

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011116

STATE FILE NUMBER  
2 2210

MAR 17 1959

Registration District No. Primary Registration District No. Registrar's No.

300  
1-57  
7  
7  
5  
0

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Christian Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>5020 W. Florissant</b>			
3. NAME OF DECEASED (Type or print) First <b>MARIETTA</b> Middle Last <b>LAMMERT</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1922</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. NAME OF HUSBAND OR WIFE <b>Harry E. Lammert Jr.</b>			
13a. FATHER'S NAME <b>Berhard Mikus</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Schallert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>496 12 6624</b>			
17. INFORMANT Address <b>Harry Lammert Jr. 5020 W. Florissant</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>anemia - recurrent &amp; severe</b> <b>adrenal cortical atrophy (Addison's Disease)</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <b>Adrenal Cortical Atrophy (Addison's Disease)</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) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6-9 mo</b> <b>6-9 mo</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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, factory, street, office bldg., etc.)			
20f. CITY, TOWN, OR LOCATION		COUNTY STATE			
21. I attended the deceased from <b>Jan 27, 59</b> to <b>March 1, 59</b> and last saw <b>her</b> alive on <b>Mar 1, 59</b> Death occurred at <b>11 P.M. 11:00 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Joshua E. Green, M.D.</b>		22b. ADDRESS <b>607 N Grand Ave</b>			
22c. DATE SIGNED <b>Mar 3, 59</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>			
23b. DATE <b>3/4/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>			
23d. LOCATION (City, town, or county) <b>St. Louis</b>		STATE <b>Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Buchholz Mortuary 5967 W. Florissant</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 3 '59</b>			
26. REGISTRAR'S SIGNATURE <b>Road Smith M.D.</b>					

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 *William J. Buchholz* .....

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.