Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015003
STATE FILE NUMBER

FILED APR 24 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 3468

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: ST. LOUIS Mo — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: 3000 MIAMI — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN: ST. LOUIS — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 3000 MIAMI — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: LOUIS — Middle: — Last: GERMANN

4. DATE OF DEATH: Month: APRIL — Day: 5 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH: SEPT 16 1888
9. AGE (In years last birthday): 70 — 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): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: CENTURY ELECTRIC
11. BIRTHPLACE (City and state or country): ILLINOIS
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: LOUIS GERMANN
13b. MOTHER'S MAIDEN NAME: LOUISIA ECKERT
14. NAME OF ~~HUSBAND~~ OR WIFE: JENNIE GERMANN (DEC'D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): YES WORLD WAR I
16. SOCIAL SECURITY NO.: 493-09-2535
17. INFORMANT: ELLA HILL — Address: 3000 MIAMI

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): Cancer of Liver
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Chronic Nephritis
DUE TO (c): Arteriosclerosis

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): 1561

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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 9/30/57 to 4/5/59 and last saw him alive on 4/4/59
Death occurred at 11 15 A.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Otto C. Homer (Degree or title) MD
22b. ADDRESS: 3012 Lafayette
22c. DATE SIGNED: 4/7/59

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE: APR-8 1959
23c. NAME OF CEMETERY OR CREMATORY: VAHALLA CHAPEL MEMORIES
23d. LOCATION (City, town, or county) (State): ST. LOUIS Mo

24. FUNERAL DIRECTOR: Thomas Lutes — ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: APR 8 '59
26. REGISTRAR'S SIGNATURE: Noal Smith, 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.

PR 1-3978
10-1 P.M. Tuesday

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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address Jennings,

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.