THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015082

STATE FILE NUMBER

FILED APR 20 1959

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 3292

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 3771 Carter Ave. — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 3771 Carter Ave. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Margaret	Middle: C.	Last: Hartmann	4. DATE OF DEATH Month Day Year: April 2 1959
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]	8. DATE OF BIRTH: March 31 1878
9. AGE (In years at last birthday): 81	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): Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Germany 4	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Bernard E. Meyer	13b. MOTHER'S MAIDEN NAME: Mary E. Bomarens	14. NAME OF HUSBAND OR WIFE: Late John Hartmann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address: Ben Hartmann 3771 Carter Ave.	

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) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 days.

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

DUE TO (c) 491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Generalized arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 1

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 April 1957, to April 1959 and last saw her alive on April 1, 1959, Death occurred at 12 30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Cecequatrin Jones, M.D.	22b. ADDRESS: 634 North Grand	22c. DATE SIGNED: 4-2-59.
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: April 4 1959	23c. NAME OF CEMETERY OR CREMATORY: St. Dominic Cemetery
23d. LOCATION (City, town, or county) (State): Breese Ill.		
24. FUNERAL DIRECTOR ADDRESS: Leidner Undertaking 2223 St. Louis Ave.	25. DATE RECD. BY LOCAL REG.: APR 2 '59	26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Albert Mansfield

Licensed Embalmer No. 1307

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failu 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.