

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015132  
STATE FILE NUMBER  
Registration District No. 3349

FILED APR 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Warren</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Warrenton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		Length of stay in lb <b>7 weeks</b>		d. STREET ADDRESS (If outside, give location) <b>West Main St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>F.</b> Last <b>Hollmann</b>			4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1878</b>		9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Warren Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>August Hollmann</b>			13b. MOTHER'S MAIDEN NAME <b>Caroline C. Vogt</b>			14. NAME OF HUSBAND OR WIFE <b>None</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>493-42-5966</b>		17. INFORMANT Address <b>Julius Hollman, 6737 Julian Ave.</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>HEMORRHAGE INTO LEFT INTERNAL CAPSULE DUE TO RUPTURE OF LENTICULO STRIATE ARTERY</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>ARTERIO SCLEROSIS</b> DUE TO (c) <b>ARTERIO SCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>33IX</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 MO</b>	
19. WAS AUTOPSY PERFORMED? 1 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 <b>Warrenton, Mo.</b>		COUNTY _____ STATE _____	
21. I attended the deceased from <b>Feb. 11, 1959</b> to <b>April 1, 1959</b> and last saw him alive on <b>3-31-59</b> Death occurred at <b>8:34 pm</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Robert Elrod M.D.</b>				22b. ADDRESS <b>35 N. Central, Clayton, Mo.</b>		22c. DATE SIGNED <b>4-3-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>4-4-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Warrenton, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>F.W. Nieburg, Warrenton, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>APR 3 '59</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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STATE OF MISSOURI - DEPARTMENT OF HEALTH - DIVISION OF HEALTH

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 *Robert M. Murray* .....

Licensed Embalmer No. *3749* .....  
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.