

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016306  
STATE FILE NUMBER

FILED APR 27 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1054

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>NORMANDY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NORMANDY OSTEOPATHIC</u>		Length of stay in lb <u>1 DAY</u>		d. STREET ADDRESS (If outside, give location) <u>3321 AIR WAY</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>JOHN</u> Last <u>HOLLMANN</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 8, 1886</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TINNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sheetmetal</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>JOHN GEORGE HOLLMANN</u>			13b. MOTHER'S MAIDEN NAME <u>KNEPPER.</u>		14. NAME OF HUSBAND OR WIFE <u>HELENE HOLLMANN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>work.</u>		17. INFORMANT Address <u>Mrs Rose E Garcia 9659 Maple Goodline</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>General Punctate Peritonitis.</u>				<u>2 hrs</u>	
		DUE TO (c) <u>Spontaneous perforation of chronic peptic ulcer pylorus.</u>				<u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>5401</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
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 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 <u>4-17-59</u> to <u>4-18-59</u> and last saw her/him alive on <u>4-18-59</u> Death occurred at <u>4:35</u> a. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>2335 Brown Rd.</u>		22c. DATE SIGNED <u>4-18-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>4-20-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>		23d. LOCATION (City, town, or county) <u>ST LOUIS</u>		(State) <u>Mo</u>
24. FUNERAL DIRECTOR <u>ORTMANN F. Home 9222 Oakland Overland Mo</u>				25. DATE RECD. BY LOCAL REG. <u>4-19-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Sam Stepanov, Student Embalmer No. 57F working under my personal supervision.

Student Sam Stepanov  
Signature of Student/Embalmer

Signed Al C Ostmann

Licensed Embalmer No. 3478

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.