

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-022551

FILED JUL 7 1959 310

Registration District No. \_\_\_\_\_ Primary Registration District No. 3058 Registrar's No. 159

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Calhoun</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Charles</b>		Length of stay in 1b <b>Minutes</b>	c. CITY OR TOWN <b>Brussels</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Charles Clinic</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Catherine Mary Pohlman</b>			4. DATE OF DEATH Month Day Year <b>July 3, 1959</b>		
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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>Jan. 4, 1885</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>28</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
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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>own</b>	11. BIRTHPLACE (City and state or country) <b>Brussels, Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Held</b>	13b. MOTHER'S MAIDEN NAME <b>Rosalie Schleeper</b>	14. NAME OF HUSBAND OR WIFE <b>John Pohlman</b>
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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>329-32-8678</b>	17. INFORMANT <b>Helen Arnold, Golden Eagle, Ill.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Heart Block</b>		<b>5 MIN</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arterio-sclerotic</b>	
	DUE TO (c) <b>hypertensive Heart Disease</b>	<b>3 years</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from **1956** to **July 3-59** and last saw her alive on **July 3-59**  
Death occurred at **10:45 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Vincent A. Schneider MD</b>	22b. ADDRESS <b>St Charles, Mo</b>	22c. DATE SIGNED <b>7/3/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>July 6, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	23d. LOCATION (City, town, or county) <b>Brussels, Illinois</b>
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24. FUNERAL DIRECTOR <b>Imming Funeral Home, Brussels, Ill.</b>	25. DATE RECD. BY LOCAL REG. <b>July 3-59</b>	26. REGISTRAR'S SIGNATURE <b>Marcella Wilson</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded, on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_ Signed Frank R. Quinn  
Signature of Student Embalmer

Licensed Embalmer No. 480  
P. O. Address St. C.

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