

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023115

STATE FILE NUMBER

2-4636

FILED JUN 19 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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1-57

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death.) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Clayton ST LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist		Length of stay in lb 2 Wks.	d. STREET ADDRESS (If outside, give location) 6254 Wydown Blvd.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Frank Landwehr			First Hospital Middle Last	4. DATE OF DEATH Month 5 Day 10 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1884	9. AGE (In years last birthday) 75	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) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Frank Landwehr		13b. MOTHER'S MAIDEN NAME Caroline Siever		14. NAME OF HUSBAND OR WIFE -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 420.0H	17. INFORMANT Address Miss Clara Landwehr, 6254 Wydown		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Heart Disease DUE TO (b) Carcinomatous DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0H					INTERVAL BETWEEN ONSET AND DEATH 10 years 6 mo.
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 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 Sept. 24, 1958 to May 10, 1959 and last saw him alive on May 10, 1959 Death occurred at 9:40 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Walter John Overall M.D. (Degree or title)			22b. ADDRESS 2256 Clayton Rd. St. Louis 19, Mo		22c. DATE SIGNED May 11, 1959
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 5/13/59	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
24. FUNERAL DIRECTOR Drehmann-Harral, 1905 Union Blvd.		25. DATE RECD. BY LOCAL REG. MAY 12 '59	26. REGISTRAR'S SIGNATURE Loan Smith M.D.		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Color, tubular, etc. must use only aluminum instruments in their use. All diseases in Part I must be causally related.

JUN 19 1959

Dr. Norton Eversoil
6356 Clayton
St 1-4060
Hrs. 12-5 Mon.

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 *Albert R. Thompson*

Licensed Embalmer No. *4237*
P. O. Address *St. Louis*

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.