

RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-030227

FILED VS AUG 27 1959

2 7606

STATE FILE NUMBER

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

DED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in 1b	c. CITY OR TOWN <u>St Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>2122 Cherokee</u> Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>J.</u> Last <u>BAMMERT</u>			4. DATE OF DEATH Month <u>AUGUST 14</u> Day <u>14</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-1877</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Shipping Clerk</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St Louis Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
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13a. FATHER'S NAME <u>Frank Bammert</u>	13b. MOTHER'S MAIDEN NAME <u>Mary VonFelton</u>	14. NAME OF HUSBAND OR WIFE <u>Lillie Bammert (Dec'd)</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>492-01-2983<sup>a</sup></u>	17. INFORMANT Address <u>Edna Heath 4135 Fillmore</u>
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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) <u>ACUTE RENAL FAILURE</u>		<u>24 HOURS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) <u>POST-OPERATIVE THROMBO-EMBOLIA RIGHT COMMON ILIAC, FEMORAL AND POPLITEAL ARTERIES</u>		<u>36 HOURS</u>
DUE TO (c) <u>ARTERIOSCLEROSIS</u>		<u>YEARS</u>

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 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year	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 <u>NOVEMBER 21, 1955</u> to <u>AUGUST 14, 1959</u> and last saw her/him alive on <u>AUGUST 14, 1959</u> Death occurred at <u>1:40 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>R. V. Bradley M.D.</u> (Doctor or title) M. D.	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>8/15/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 17 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>S S Peter and Paul Cem St Louis</u>	23d. LOCATION (City, town, or county) (Sta :) <u>Mo</u>
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24. FUNERAL DIRECTOR <u>Thomas Kutis 2906 Gravois</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>AUG 17 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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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 by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Eleanore*

Licensed Embalmer No. 3403

P. O. Address 2906 Glen

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