

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS SEP 21 1959**

**59-033531**

**2 8384**

STATE FILE NUMBER

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

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>                       |  | c. CITY OR TOWN <b>St. Louis</b>  |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>4329 Loughborough Ave</b> |  | d. STREET ADDRESS (If outside, give location) <b>4329 Loughborough Ave</b>  |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>BACHMANN</b> Last |  |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>9</b> Year <b>1959</b> |  |  |
|---|--|--|--|--|--|

|                       |                                  |   |                                      |  |
|-----------------------|----------------------------------|---|--------------------------------------|--|
| 5. SEX<br><b>Male</b> | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-19-1885</b> | 9. AGE (last birthday)<br>Months <b>73</b> Days Hours Min. |
|-----------------------|----------------------------------|---|--------------------------------------|--|

|  |                                   |   |  |
|--|-----------------------------------|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Brewer</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country)<br><b>Illinois</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b> |
|--|-----------------------------------|---|--|

|   |   |   |
|---|---|---|
| 13a. FATHER'S NAME<br><b>Charles Bachmann</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Dora Eckert</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Anna Bachmann</b> |
|---|---|---|

|   |                         |  |
|---|-------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO. | 17. INFORMANT/Address<br><b>Anna Bachmann 4329 Loughborough Av</b> |
|---|-------------------------|--|

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Lung</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mos.</b> |
| DUE TO (b) _____   |  |   |
| DUE TO (c) _____   |  |   |

|  |  |
|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>163x</b> | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
|--|--|

|   |   |  |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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.) |
|---|---|--|

|   |
|---|
| 20c. TIME OF INJURY<br>Hour _____ s.m. _____ p.m. _____<br>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 |
|--|--|------------------------------|--------|-------|

21. I attended the deceased from **21 Aug. 59** to **5 Sept. 59** and last saw him alive on **Sept 9, 1959**  
Death occurred at **6:10 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

|  |  |  |
|--|--|--|
| 22a. SIGNATURE (Degree or title)<br><b>Thomas F. Gan, M.D.</b> | 22b. ADDRESS<br><b>1515 Lafayette Ave.</b> | 22c. DATE SIGNED<br><b>Sept 10, 1959</b> |
|--|--|--|

|   |                               |   |   |
|---|-------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>9-11-1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Burial Park</b> | 23d. LOCATION (City, town, or county) (State)<br><b>10160 Gravois Rd Mo</b> |
|---|-------------------------------|---|---|

|   |  |
|---|--|
| 25. DATE RECD. BY LOCAL REG.<br><b>SEP 10 '59</b> | 26. REGISTRAR'S SIGNATURE<br><b>Neal Smith, M.D.</b> |
|---|--|

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**Bezenhem Bros**  
FUNERAL DIRECTOR  
ADDRESS **6409 Gravois Av**

**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 Yan M. Sizemore

Licensed Embalmer No. 4343

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.