

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
EILED VS OCT 5 1959

59-033873

2 8521

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN 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 Lutheran Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 3012 Lafayette Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First OTTO Middle C. Last HANSER				4. DATE OF DEATH Month 9 Day 14 Year 59									
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7/5/83		9. AGE (last birthday) 76 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician			10b. KIND OF BUSINESS OR INDUSTRY Medical Doctor		11. BIRTHPLACE (City and state or country) St. Louis, Mo.			12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Robert Hanser				13b. MOTHER'S MAIDEN NAME Mathilda Menkens				14. NAME OF HUSBAND OR WIFE Clara L. Faudi Hanser					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (if yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Otto C. Hanser 58 Briarcliff (24)								
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) Acute Myocardial Infarction										36 hours			
DUE TO (b) Arteriosclerotic Heart Disease										5 years			
DUE TO (c) T.D.O.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus										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			
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.)									
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				
21. I attended the deceased from 8/1/59 to 9/14/59 and last saw ^{her} him alive on 9/13/59 Death occurred at 7:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Frede Mortensen, M.D.					22b. ADDRESS 3701 Grandel Square				22c. DATE SIGNED 9/14/59				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9/16/59		23c. NAME OF CEMETERY OR CREMATORY Sun Set Burial Park			23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.						
24. FUNERAL DIRECTOR E.J. Schnur 3125 Lafayette Ave.				25. DATE RECD. BY LOCAL REG. SEP 16 '59		26. REGISTRAR'S SIGNATURE Roal Smith, M.D.							

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 me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Thomas R. Demwick

Licensed Embalmer No. 3793

P. O. Address 3125 Lafayette

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.