

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034153

FILED VS SEP 16 1959

2 8143

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 9 yrs	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 checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1945 Withnell Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First PETER Middle OHLHAUSEN Last	4. DATE OF DEATH Month September Day 1 Year 1959
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5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/3/1906	9. AGE (last birthday) 52	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance man	10b. KIND OF BUSINESS OR INDUSTRY photography service	11. BIRTHPLACE (City and state or country) Liebling, Rumania	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Friederich Ohlhausen	13b. MOTHER'S MAIDEN NAME Barbara Munz	14. NAME OF HUSBAND OR WIFE Elizabeth Gross
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. _____	17. INFORMANT Mrs. Elizabeth Ohlhausen, 1945 Withnell Address _____
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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: IMMEDIATE CAUSE (a) Cancer of Stomach		INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Metastases to Liver	
	DUE TO (c) 151x	

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 **9-22-59** **to** **9-1-59** **and last saw him alive on** **9-1-59**
Death occurred at **9:15 a.** **m** **on the date stated above, and to the best of my knowledge, from the causes stated.**

22a. SIGNATURE <i>W. H. Huser M.D.</i> (Degree or title)	22b. ADDRESS 3701 Grandel St	22c. DATE SIGNED 9/2/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Sept. 4, 1959	23c. NAME OF CEMETERY OR CREMATORY Concordia Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri
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24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave	25. DATE RECD. BY LOCAL REG. SEP 2 1959	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Theo. H. Hanser,
1-4 PM
3701 Grandel Square

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 Homer W. Juity

Licensed Embalmer No. 3882

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.