

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 23 1959

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211427

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)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		a. STATE Mo	b. COUNTY
Length of stay in 1b Life		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 De Paul Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 300 Humboldt
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First Margaret	Middle E	Last Holtgrewe	4. DATE OF DEATH Month Dec	Day 8	Year 1959
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5. SEX Female	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 11/27/1907	9. AGE (last birthday) 52	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) St Louis Mo	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Joseph A. Schrader	13b. MOTHER'S MAIDEN NAME Annie Weinbrenner	14. NAME OF HUSBAND OR WIFE George Holtgrewe
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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) NO	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Jerry Holtgrewe 300 Humboldt St L Mo
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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 2 1/2 weeks
IMMEDIATE CAUSE (a) Brain Tumor (cerebellum)	DUE TO (b)	Acute symptoms
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Mild arterio-sclerotic-heart disease	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 None	Hour a.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St Louis Mo	COUNTY	STATE
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21. I attended the deceased from 8 P.M. November 21, 1959 to Dec. 8, 1959 and last saw her live on Dec. 8, 1959	Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Deceased or title) Gertrude A. Holtgrewe AM	22b. ADDRESS 2435 N. Grand Blvd	22c. DATE SIGNED 12-4-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/11/1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St Louis Mo
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24. FUNERAL DIRECTOR Ortmann F Home	ADDRESS 9222 Lackland Overland Mo	25. DATE RECD. BY LOCAL REG. DEC 9 1959	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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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 Al C. Outmann

Licensed Embalmer No. 3478

P. O. Address _____

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.