

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002994

FILED VS FEB 11 1960

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 33

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>ST. CHARLES</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. CHARLES</u>		Length of stay in 1b <u>19 YRS</u>		c. CITY OR TOWN <u>ST. CHARLES</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>929 N. THIRD STR</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>929 N. THIRD STR</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>EHLMANN</u> Last <u>EHLMANN</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>2</u> Year <u>1960</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>SEPT 9, 1882</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>24</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDNER & YARDMAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		11. BIRTHPLACE (City and state or county) <u>ST. CHARLES CO. MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		
13a. FATHER'S NAME <u>HERMAN EHLMANN</u>			13b. MOTHER'S MAIDEN NAME <u>DOROTHEA PRIEP</u>			14. NAME OF HUSBAND OR WIFE <u>ANNA ELIZ EHLMANN 1957</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>WALTER J. H. EHLMANN, ST. CHARLES MO RT. # 2.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT WOUND IN FOREHEAD (22 CAL. RIFLE)</u> DUE TO (b) <u>APPARENTLY SELF INFLICTED</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</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			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input checked="" 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Marie Muehling Corona</u>				22b. ADDRESS <u>Wentzville mo Feb 3, 1960</u>				22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>FEB. 5, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ZION LUTHERAN CEM</u>		23d. LOCATION (City, town, or county) (State) <u>RT # 2, ST. CHARLES MO</u>				
24. FUNERAL DIRECTOR ADDRESS <u>C. L. PRINSTER, ST. CHARLES, MO</u>				25. DATE RECD. BY LOCAL REG. <u>2/3/60</u>		26. REGISTRAR'S SIGNATURE <u>Mirella Wilson</u>			

MEDICAL CERTIFICATION

DOCUMENT

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 Howard O. Kesler

Licensed Embalmer No. 4637

P. O. Address Wentzville

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.