

# MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004569

FILED VS FEB 1 1960 317

Registration District No. \_\_\_\_\_ Primary Registration District No. 500 Registrar's No. 155

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bellefontaine Neighbors</u> Length of stay in 1b <u>1 1/2 yrs. 6 mos.</u> c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) <u>St. Louis State School &amp; Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>BELLEFONTAINE NEIGHBORS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>10695 BELLEFONTAINE RD.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>Kenneth</u> Middle <u>George</u> Last <u>Hannick</u>			<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>15</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 5, '42</u>	9. AGE (last birthday) <u>17 yrs.</u>	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)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Charles J. Hannick</u>	13b. MOTHER'S MAIDEN NAME <u>Bernice Strawn</u>	14. NAME OF HUSBAND OR WIFE _____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. _____
17. INFORMANT <u>Records of St. Louis State School &amp; Hosp.</u>		Address <u>10695 Bellefontaine Rd. St. Louis 37, Mo.</u>

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> DUE TO (b) <u>Epilepsy</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>2 days</u>  <u>Life</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Mental Deficiency</u>		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 July 15, 1948 to Jan. 15, 1960 and last saw <sup>her</sup>him alive on Jan 15, 1960  
 Death occurred at 11:40 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Donald M. Ellersich, M.D.</u>		22b. ADDRESS <u>10695 Bellefontaine Rd.</u>		22c. DATE SIGNED <u>1-15-60.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JAN. 18, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY, MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>PFITZINGER MORTUARY, KIRKWOOD</u>		25. DATE RECD. BY LOCAL REG. <u>1-15-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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 *Leo Hoffmann*

Licensed Embalmer No. 436

P. O. Address *Haus*

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.