URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

MAR 1 4 1960

[redacted]

ENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2004 STATE FILE NUMBER 60-008735

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 6 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: DePaul
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Jennings
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2155 Fairhaven Dr.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle H Last POHLMANN
4. DATE OF DEATH: Month February Day 19 Year 1960
5. SEX: male
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10/10/90
9. AGE (last birthday): 69 years
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): Contractor
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (City and state or country): Germany
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: Henry Pohlmann
13b. MOTHER'S MAIDEN NAME: Anna Hoensel
14. NAME OF HUSBAND OR WIFE: Clara Pohlmann
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.: 500-18-8894
17. INFORMANT: Clara Pohlmann - 2155 Fairhaven Dr. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Carcinoma of Larynx with
DUE TO (c) Metastasis 161 X
INTERVAL BETWEEN ONSET AND DEATH
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. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Sept 1958, to 2/19/60 and last saw ~~her~~ him alive on 2/18/60
Death occurred at 9:45 pm m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Gerald J. Carroll M.D.
22b. ADDRESS: 607 N. Grand
22c. DATE SIGNED: 2/19/60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 2/22/60
23c. NAME OF CEMETERY OR CREMATORY: Bethlehem Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri
24. FUNERAL DIRECTOR ADDRESS: BUCHHOLZ MORT.-5967 W.Florissant Ave.
25. DATE RECD. BY LOCAL REG.: FEB 21 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. MDC

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.