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| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>ST. Louis</u>                        |  | c. CITY OR TOWN <u>ST. Louis</u>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Alexian Bros. Hospital</u> |  | d. STREET ADDRESS (If outside, give location)<br><u>3400 S. Grand Ave.</u>  |  |

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| 3. NAME OF DECEASED (Type or print)<br>First <u>August</u> Middle <u>H.</u> Last <u>Maas</u> |  |  | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>28</u> Year <u>1960</u> |  |  |  |
|--|--|--|--|--|--|--|

|                       |                                  |   |   |                                     |                           |                        |                         |                        |
|-----------------------|----------------------------------|---|---|-------------------------------------|---------------------------|------------------------|-------------------------|------------------------|
| 5. SEX<br><u>Male</u> | 6. COLOR OR RACE<br><u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 30, 1899</u> | 9. AGE (last birthday)<br><u>71</u> | IF UNDER 1 YEAR<br>Months | IF UNDER 24 HR<br>Days | IF UNDER 24 HR<br>Hours | IF UNDER 24 HR<br>Min. |
|-----------------------|----------------------------------|---|---|-------------------------------------|---------------------------|------------------------|-------------------------|------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Ware House Man</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>J. C. Penney</u> | 11. BIRTHPLACE (City and state or country)<br><u>ST. Louis, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>U. S. A.</u> |
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| 13a. FATHER'S NAME<br><u>Henry Maas</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Francis Jansen</u> | 14. NAME OF HUSBAND OR WIFE<br><u>None</u> |
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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)<br><u>No</u> | 16. SOCIAL SECURITY NO.<br><u>578X</u> | 17. INFORMANT<br><u>Joseph H. Maas</u> | Address<br><u>4620 Minnesota</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                          |  | INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (a) <u>GENERALIZED Peritonitis</u>  |  | <u>10 days</u>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <u>Crohn obstruction &amp; double perforation</u> | <u>10 days</u>  |
|   | DUE TO (c) <u>arterioelastic ex heart disease</u>            | <u>-5 yrs.</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 |

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| 19. WAS AUTOPSY PERFORMED?<br>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.)<br><u>578X</u> |
|---|---|---|

|                                      |                  |
|--------------------------------------|------------------|
| 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 Oct. 11, 1960 to Oct. 28, 1960 and last saw her him alive on Oct 28, 1960  
Death occurred at 6 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE<br><u>[Signature]</u> (Degree or title) | 22b. ADDRESS<br><u>1901 Madison St</u> | 22c. DATE SIGNED<br><u>10/28/60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 23b. DATE<br><u>Oct. 31, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>S. S. Peter + Paul Cem.</u> | 23d. LOCATION (City, town, or county)<br><u>ST. Louis, Mo.</u> |
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| 24. FUNERAL DIRECTOR<br><u>Witt Bros. L. &amp; U. G.</u> | ADDRESS<br><u>2929 S. Jefferson</u> | 25. DATE RECD. BY LOCAL REG.<br><u>OCT 28 1960</u> | 26. REGISTRAR'S SIGNATURE<br><u>Carl Smith, M.D.</u> |
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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 Harold E. With

Licensed Embalmer No. 4353

P. O. Address 2727 S. Jefferson

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.