

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004099  
STATE FILE NUMBER

FILED VS. JAN 16 1961 317  
Registration District No. 317 Primary Registration District No. 500 Registrar's No. 14

DATE AMENDED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Normandy</b>		Length of stay in 1b <b>1 Month</b>	c. CITY OR TOWN <b>Pine Lawn</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hilltop House</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7040 Lillian Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>CAROLINE G. MASCHMANN</b>			4. DATE OF DEATH Month Day Year <b>Jan. 1 1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-31-1873</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Gallus Koenig</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>Late Martin Maschmann</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Gallus J. Maschmann 7040 Lillian Ave.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>years</b>
DUE TO (b) <b>A C H D</b>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Senility</b>		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

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 <b>6/14/53 11/2/61</b>	COUNTY <b>St. Louis</b>	STATE <b>Mo.</b>
21. I attended the deceased from <b>6/14/53</b> to <b>11/2/61</b> and last saw her <b>12/29/60</b> alive on Death occurred at <b>12:30 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <b>Robert A Bauer MD</b>	22b. ADDRESS <b>3731 Goodfellow</b>	22c. DATE SIGNED <b>1/3/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Jan. 4, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>

24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>1-3-61</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

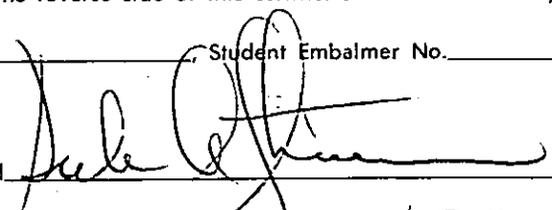
BY AFFIDAVIT OF

MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 4533

P. O. Address \_\_\_\_\_

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.