

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

8334

61-034427

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8334 STATE FILE NUMBER

FILED SEP 18 1961

AMENDED

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis, Mo.** Length of stay in 1b _____
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Lutheran Hosp.** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **Missouri** COUNTY _____
 c. CITY OR TOWN **St. Louis** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **6713 Alabama** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last **William J. Hase**
 4. DATE OF DEATH Month Day Year **Sept. 5, 1961**

5. SEX **male** 6. COLOR OR RACE **white** 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH **Aug. 18, 1884** 9. AGE (last birthday) **77** 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) **ret. Butcher grocery Store Owner** 10b. KIND OF BUSINESS OR INDUSTRY _____
 11. BIRTHPLACE (City and state or country) **St. Louis, Mo.** 12. CITIZEN OF WHAT COUNTRY **USA**

13a. FATHER'S NAME **Frank Hase** 13b. MOTHER'S MAIDEN NAME **Mary Lighthorst** 14. NAME OF HUSBAND OR WIFE **Irene Hase**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **no** 16. SOCIAL SECURITY NO. **none** 17. INFORMANT Address **Mo. Irene Hase 6713 Alabama, St. Louis**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Cerebral hemorrhage** INTERVAL BETWEEN ONSET AND DEATH **48 hrs.**
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **331 x**
 DUE TO (c) _____

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 **May 1961** to **9/5/61** and last saw him alive on **9/5/61**
 Death occurred at **930 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **R. H. Schmeissner M.D.** 22b. ADDRESS **6817 Noxois** 22c. DATE SIGNED **9/8/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **removal** 23b. DATE **9-8-61** 23c. NAME OF CEMETERY OR CREMATORY **Mt. Olive Cem.** 23d. LOCATION (City, town, or county) **Lemay, Mo.**

24. FUNERAL DIRECTOR ADDRESS **Southern Funeral Home 6322 S. Grand, St. Louis, Mo.** 25. DATE RECD. BY LOCAL REG. **SEP 7 1961** 26. REGISTRAR'S SIGNATURE **Lead Smith, M.D.**

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 David Van Fossan

Licensed Embalmer No. 4242

P. O. Address St Louis Mo

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.