

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

1166E

-61-046364

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

AMENDED

**FILED DEC 21 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b	a. STATE <b>Missouri</b> COUNTY <b>Crawford</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Steelville</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
		d. STREET ADDRESS <b>Rt 2,</b>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Adolph A. HAHN</b>			4. DATE OF DEATH Month Day Year <b>DECEMBER 12 1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-2-1898</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months Days <b>1 10</b>	IF UNDER 24 HR Hours Min. <b>10</b>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wild wood or industry care taker</b>	11. BIRTHPLACE (City and state or country) <b>Resort Steelville Mo St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Adolph Hahn</b>	13b. MOTHER'S MAIDEN NAME <b>Caroline Klugman</b>	14. NAME OF HUSBAND OR WIFE <b>Paula Hahn</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Nil</b>	17. INFORMANT <b>Veras Simmerock</b> Address: <b>Rt 9 Box 664 K St Louis 29 Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>RUPTURE OF DISSECTING ANEURYSM OF AORTA</b>		<b>3 DAYS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>451x</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>HEMOPERICARDIUM WITH RUPTURE AT BASE OF AORTA</b>		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? 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.)
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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
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21. I attended the deceased from <b>DEC. 10, 1961</b> to <b>DEC. 12, 1961</b> and last saw her/him alive on <b>DEC. 12, 1961</b> Death occurred at <b>9:50 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Chas. L. Roper</b> (Degree or title) <b>Charles L. Roper M.D.</b>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>12/13/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Dec 15 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Burial Park</b>	23d. LOCATION (City, town, or county) (State) <b>Affton 23, Mo.</b>
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24. FUNERAL DIRECTOR <b>Fey Funeral Home, Mehlville Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>DEC 14 1961</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>
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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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Gustav W. Dichter*

Licensed Embalmer No.

*4329*

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.