

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046621

318

1003

12273

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

FILED JAN 11 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b <b>2 mo. 10 days</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis State Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3626 S. Jefferson Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>(FRITZ)</b> Last <b>MASSMANN</b>	4. DATE OF DEATH Month <b>Dec.</b> Day <b>28,</b> Year <b>1961</b>
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5. SEX <b>Male</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>9-13-1883</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>formerly: Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Owned farm</b>	11. BIRTHPLACE (City and state or country) <b>Washington, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Charles Massmann</b>	13b. MOTHER'S MAIDEN NAME <b>Marie Jacobsmeyer</b>	14. NAME OF HUSBAND OR WIFE <b>Emma Massmann</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Lester Massmann, 5024 Alcott Ave.</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>Peripheral vascular shock</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Upper gastrointestinal hemorrhages</b> DUE TO (c) <b>Duodenal ulcers</b> <b>541.0</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic heart disease, senility</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 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.)
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20c. TIME OF INJURY Hour <b>1:45</b> 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>10-18-61</b> to <b>12-28-61</b> and last saw <sup>her</sup> him alive on <b>12-28-61</b> Death occurred at <b>Thomas Thale, M.D.</b> <b>1:45</b> a. m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Thomas Thale M.D.</i> (Degree or title)	22b. ADDRESS <b>5400 Arsenal St.</b>	22c. DATE SIGNED <b>12-28-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>Dec. 30, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Washington, Missouri</b>
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24. FUNERAL DIRECTOR <b>Nieburg &amp; Co., Washington, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 29 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loed Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 8 1962  
JAN 30 1962

**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 *Lester A. Pitt*

Licensed Embalmer No. *3254*  
P. O. Address *Washington*

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.