

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

1574-62-008541  
STATE FILE NUMBER

318 Primary Registration District No. 1003 Registrar's No.

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318  
FILED FEB 29 1962

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT
1			
2 22 1/2			
3			
4 0			
5 0			
6			
7 0			
8 2			
9			
10			
11			
12 90-3			
13			
90	SHOULD READ	BY AFFIDAVIT OF	

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
Length of stay in lb		d. STREET ADDRESS (If outside, give location) 2827 S. 18th ST	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD W OHLENDORF		4. DATE OF DEATH Month Day Year FEB 3 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH AUG 9 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SERVICE MAN		10b. KIND OF BUSINESS OR INDUSTRY DEERE CO	11. BIRTHPLACE (City and state or country) MISSOURI
13a. FATHER'S NAME CHRISTIAN A OHLENDORF		13b. MOTHER'S MAIDEN NAME JOHANNA BLUMBERG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT EMIL F. OHLENDORF 1167 13AVE MOLINE ILL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic heart disease; DUE TO (b) Arterio Sclerosis. DUE TO (c) 4200		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 s.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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ 10:15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Helen L. Taylor, Coroner		22b. ADDRESS 1300 Clark Ave.	
22c. DATE SIGNED 2/6/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE FEB 7 1962	
23c. NAME OF CEMETERY OR CREMATORY ST. PETER CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON MO.	
24. FUNERAL DIRECTOR Thomas Hutia 2906 Gravois		25. DATE RECD. BY LOCAL REG. FEB 6 1962	
		26. REGISTRAR'S SIGNATURE Road Smith, M.D.	

Embalm (OT)

**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 *Earl T. [Signature]*

Licensed Embalmer No. 4861

P. O. Address State 5, 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.