

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-013282  
 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **3426**

**FILED APR 6 1962**

VS 300  
 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT BY AFFIDAVIT OF

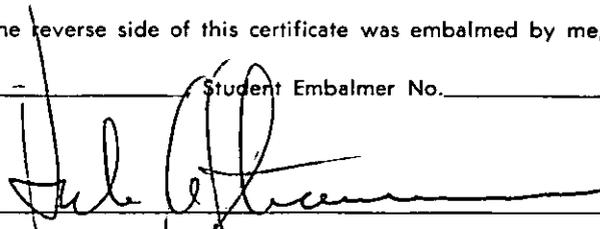
1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>		c. CITY OR TOWN <b>Washington</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Alexian Bros. Hospital</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1506 41st St. South East</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>R.</b> Last <b>VAN ERMEN</b>			4. DATE OF DEATH Month <b>Mar.</b> Day <b>31</b> Year <b>1962</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		
8. DATE OF BIRTH <b>3-10-1922</b>		9. AGE (last birthday) <b>40</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Admitting Clerk-General Hosp.-Washington, D.C.</b>		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (City and state or country) <b>Madison, Wisconsin</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				13a. FATHER'S NAME <b>Louis VanErmen</b>		13b. MOTHER'S MAIDEN NAME <b>Ruth Stormer</b>		14. NAME OF HUSBAND OR WIFE -----	
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>None</b>		17. INFORMANT Address <b>LaMarque, Louis VanErmen 2811 Houston Dr. Texas</b>							
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Complications of surgery</b>										<b>6 mos</b>			
DUE TO (c) <b>161X</b>													
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. <input type="checkbox"/> Yes <input 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		COUNTY STATE			
21. I attended the deceased from <b>Mar. 29, 1962</b> to <b>Mar. 31, 1962</b> and last saw her/him alive on <b>Mar 30, 1962</b> Death occurred at <b>12:05 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>Ray C. Ruppel M.D.</b>						22b. ADDRESS <b>7702 Irving</b>			22c. DATE SIGNED <b>3/31/62</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)					
<b>Removal (Rail)</b>		<b>Mar. 31, 1962</b>		<b>Green Bay, Wisconsin</b>									
24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>						25. DATE RECD. BY LOCAL REG. <b>MAR 31 1962</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>					

**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  \_\_\_\_\_  
Student Embalmer No. \_\_\_\_\_

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.