

No. 2
1-10-39
-17-39
X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43900

State File No. 0

Registration District No. 784

Primary Registration District No. 111

Registrar's No. 2356

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Rich Hill MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St Marys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 1/2 Days
(Specify whether
In this community 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St Louis MO
(If outside city or town limit: write "RURAL")

(d) Street No 1105 Mc Causland Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME ANNA-BARBARA-MOHRMAN

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Edward St Mohrman

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Aug 21 1887
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>53</u>	<u>3</u>	<u>21</u>	<u>5 hr. 10 min.</u>

9. Birthplace Cincinnati Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Peter Grossman

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Barbara Larsman

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Edwin X Mohrman

(b) Address 1105 Mc Causland Ave

17. (a) Burial (b) Date thereof 12/14/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Waton Bookage

(b) Address 6536 Clayton Rd

19. (a) DEC 13 1940 (b) L R Myers MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 12
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 12/17
1940, to Dec 12, 1940
that I last saw h. er alive on Dec 11, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage, left side Duration 7 day

Due to arterio sclerosis and infarction 3 min

Due to chronic nephritis 1 year

Other conditions non
(Include pregnancy within 3 months of death)

Major findings: 131
Of operations no operat

Of autopsy Cerebral hemorrhage - entire left parietal part of temporal & frontal lobes. 2 degenerative cysts left lateral ventricle. 1 degenerative cyst right lateral ventricle.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 221

(b) Date of occurrence X

(c) Where did injury occur? X (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? X

While at work? X (Specify type of place) (e) Means of injury X

23. Signature L H T Hirschel (M. D. or other) 1290

Address 3500 N Grand Date signed 12/12/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed Guy W Wilkinson

Licensed Embalmer No. 3572

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 this body is not embalmed, above space should be left blank.