

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2483  
Registrar's No. 000

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital-Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community LIFE (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County \_\_\_\_\_  
(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1935<sup>A</sup> REAR MONTGOMERY  
Memorial (If rural, give location)  
(e) Citizen of foreign country? = (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JESSE FLOTTMANN  
3. (b) If veteran, name war = 3. (c) Social Security No. =

4. Sex MALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced CHILD  
6. (b) Name of husband or wife = 6. (c) Age of husband or wife if alive = years  
7. Birth date of deceased JUNE 23 1946  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
6 11 hr. min.

9. Birthplace St. Louis (City, town, or county) (State or foreign country) 0  
10. Usual occupation Chief

11. Industry or business =  
12. Name ERWIN FLOTTMANN  
13. Birthplace ST. LOUIS (City, town, or county) (State or foreign country)  
14. Maiden name FLORA HOGAN  
15. Birthplace MISSOURI (City, town, or county) (State or foreign country)

16. (a) Informant Erwin Flottmann  
(b) Address 1935<sup>A</sup> rear Montgomery  
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Jan 6 1946  
(Month) (Day) (Year)  
(c) Place: burial or cremation Covered

18. (a) Signature of funeral director Benedict Funeral Home  
(b) Address 1936 1/2 E. Union Ave.  
19. (a) JAN 2 1947 (Date received local registrar) (b) J. F. Brodeur (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 4th  
year 1947 hour 3:25 minute A M.  
21. I hereby certify that I attended the deceased from 11/18/46  
1/4/47 to 1/4/47, 19\_\_\_\_, to 1/4/47, 19\_\_\_\_;  
that I last saw h. im alive on 1/4/47, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid Hemorrhage  
Septic Pathogenic meningitis on the left  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) None  
Major findings: 1/60  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
23. Signature swy club MO (Specify type of place) (b) Means of injury 0  
1515 Lafayette (c) Date signed 1/4/47

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

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

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**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..... *Malcolm Paulson* .....

Licensed Embalmer No. *4114* .....

P. O. Address. *1936 St. Louis Ave* .....

**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, fact should be so stated above.**