

FILED FEB 24 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6685

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>1444</b>	
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, write RURAL and give town) <b>ST. LOUIS</b>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) <b>ST. LOUIS</b>		2029	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5704 ROSA AV.</b>				d. STREET ADDRESS (If rural, give location) <b>2 - 5704 ROSA AV.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>WILLIAM</b> b. (Middle) <b>S.</b> c. (Last) <b>SAHRMANN</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>FEB. - 12 - 50</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>FEB-3-1878</b>	
9. AGE (In years last birthday) <b>72 YRS</b>		IF UNDER 1 YEAR Months   Days		IF UNDER 10 YRS. Hours   Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>HENRY SAHRMAN</b>		13b. MOTHER'S MAIDEN NAME <b>MARGARET RUSSELL</b>		14. NAME OF HUSBAND OR WIFE <b>MARGARET SAHRMANN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Margaret Sahrman 5704 Rosa Av.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Apoplexy</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive Cerebrovascular Disease</b> DUE TO (c) <b>Disease</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Cerebrum Large Blood</b>				INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>Ten yrs.</b> <b>Two yrs.</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>ST. LOUIS MO.</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan 15, 1950</b> , to <b>Feb 12, 1950</b> , that I last saw the deceased alive on <b>Feb 11, 1950</b> , and that death occurred at <b>11:45 A.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Robert A. Biennen M.D.</b>				23b. ADDRESS <b>5417 South Grand</b>		23c. DATE SIGNED <b>2-15-50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>FEB-15-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>CALVARY</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO.</b>	
DATE REC'D BY LOCAL REG. <b>FEB 14 1950</b>		REGISTRAR'S SIGNATURE <b>J. B. [Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>E. J. Schmur 3125 Lafayette Av.</b>			

WRITE PLAINLY—USING 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 \_\_\_\_\_

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4814

P. O. Address 3125 La Puente

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.