

FILED NOV 8 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35631

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9507**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS, MISSOURI		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2129	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 5038 Cabanne e	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL			
3. NAME OF DECEASED (Type or Print) a. (First) LOUIS		b. (Middle)	c. (Last) SOMMER
4. DATE OF DEATH (Month) (Day) (Year) 10 26 51			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH About 1900
9. AGE (In years last birthday) 51 ?	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Importer		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (State or foreign country) Rhinebach, Germany 4
12. CITIZEN OF WHAT COUNTRY? U S			
13a. FATHER'S NAME Lazarus Sommer		13b. MOTHER'S MAIDEN NAME Pauline Stienberg	14. NAME OF HUSBAND OR WIFE Giovanna Sommer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Giovanna Sommer 5038 Cabanne Ave
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) VENTRICULAR FIBRILLATION ANTECEDENT CAUSES DUE TO (b) HYPERTENSION <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 444 X
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H	
22. I hereby certify that I attended the deceased from 10/25 51 , to 10/26 , 19 51 , that I last saw the deceased alive on 10/26 , 19 51 , and that death occurred at 2:10 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) G. J. Verinella, M.D.		23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 10/26
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE 11-3-51	24c. NAME OF CEMETERY OR CREMATORY Valhalla Crem.	24d. LOCATION (City, town, or county) (State) St. Louis, Co. Mo.
DATE REC'D BY LOCAL REG. OCT 27 1951	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington	

(Licensed Embalmer's Statement on Reverse Side)

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

300
48

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

John S. Renne

Licensed Embalmer No. *4194*

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.