

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6205

State File No. ....

FILED MAR 5 1952

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 1568

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY OR TOWN ST. LOUIS MO		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL		d. STREET ADDRESS (If rural, give location) 16 2851 MINNESOTA	
3. NAME OF DECEASED (Type or Print) LOTTIE - BACHMANN		4. DATE OF DEATH (Month) (Day) (Year) FEB. 16 1952	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAY 5 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIDOW		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	9. AGE (In years last birthday) 71
13a. FATHER'S NAME GUSTAV TROST		13b. MOTHER'S MAIDEN NAME PHILLIPINE MERTZ	14. NAME OF HUSBAND OR WIFE OTTO BACHMANN
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 JULIUS W. BACHMAN 3123 TEXAS
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) Chronic Lymphocytic Leucemia DUPLICATE (b) Aplastic Anemia DUPLICATE (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) (Minute)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 2040	
22. I hereby certify that I attended the deceased from 1948, 19, to 2/16, 1952, that I last saw the deceased alive on 2/16, 1952, and that death occurred at 5:30 P. M., from the causes and on the date stated above.			
23a. SIGNATURE Charles G. Benneyer (Degree or title) MD		23b. ADDRESS 3123 Texas St.	
23c. DATE SIGNED 2/18/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) FEB. 19 1952		24b. DATE	
24c. NAME OF CEMETERY OR CREMATORY ST. PAUL'S CHURCHYARD		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 19 1952		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kute 2906 Geavies	

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed Leo J. Buddle

Licensed Embalmer No. 3989

P. O. Address 2906 Grand

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.