

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32033

State File No. ....

8024

FILED SEP 16 1954

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. ....

<b>1. PLACE OF DEATH</b> a. COUNTY  b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. Louis</u> c. LENGTH OF STAY (In this place)  d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3729 Cottage</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY  c. CITY OR TOWN <u>ST. Louis</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) <u>11 3729 Cottage Ave</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Charles J. Mohrman</u> a. (First) b. (Middle) c. (Last)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>8-30-54</u>	
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>	
<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>MARRIED</u>		<b>8. DATE OF BIRTH</b> <u>11-8-1890</u>	
<b>9. AGE</b> (In years last birthday) <u>63</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Cutter</u>	
<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <u>ST. Louis Mo</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13a. FATHER'S NAME</b> <u>Joe Mohrman</u>		<b>13b. MOTHER'S M.A.D.D.E.N NAME</b> <u>Not known</u>	
<b>14. NAME OF HUSBAND OR WIFE</b> <u>MABEL MOHRMAN</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWI</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>494-09-3966</u>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>Mabel Mohrman</u>	
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Coronary</u> ANTECEDENT CAUSES <u>Thrombosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	
<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED WHILE AT WORK -</b> NOT WHILE AT WORK <input type="checkbox"/>	
<b>21f. HOW DID INJURY OCCUR?</b> <u>42.01</u>			
<b>22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6:30 A.M.</u>, from the causes and on the date stated above.</b>			
<b>23a. SIGNATURE</b> (Degree or title) <u>Meribeth Taylor Corwin</u>		<b>23b. ADDRESS</b> <u>300 West</u>	
<b>23c. DATE SIGNED</b> <u>9-8-54</u>			
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>		<b>24b. DATE</b> <u>9-1-54</u>	
<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Peter + Paul</u>		<b>24d. LOCATION</b> (City, town, or county) (State) <u>St. Louis Mo</u>	
<b>DATE REC'D BY LOCAL REG.</b> <u>AUG 31 1954</u>		<b>REGISTRAR'S SIGNATURE</b> <u>J. Carl Smith, M.D.</u>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Okon Hill</u>		<b>ADDRESS</b> <u>27071 Grand</u>	

5.0 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

*J. Allen Rainey*  
Licensed Embalmer No. *46*  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.