

FILED JAN 26 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2734

400

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>St Louiss</u>		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL #1.</u>				e. STREET ADDRESS (If rural, give location) <u>25 218 So 4th St</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>LOGAN</u> b. (Middle) <u>F</u> c. (Last) <u>HACHMAN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 6, 1956</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>April 8, 1887</u>		
9. AGE (in years last birthday) <u>68</u>		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours		IF UNDER 15 MIN. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Evansville, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Peter Hachman</u>			13b. MOTHER'S MAIDEN NAME <u>Louisa Sternagel</u>		14. NAME OF HUSBAND OR WIFE <u>Lydia Hackman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Lydia Hachman, 5099 Westminister</u>				
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Probable Myocardial Infarction</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>also: Post operative Bleeding</u> <u>Dissecting Ulcer</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>420.1</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)				
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 <u>12-15</u> , 19 <u>55</u> , to <u>6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-6</u> , 19 <u>56</u> , and that death occurred at <u>12:50 P.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>W. J. Martin, M.D.</u>				23b. ADDRESS <u>1515 LAFAYETTE AVE.</u>		23c. DATE SIGNED <u>1-6-56</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>1-12-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>JAN 12 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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.....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 295

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.