

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34248

STATE FILE NUMBER

FILED OCT 11 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8998**

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St Louis</b>                                       |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b>  |  | c. CITY OR TOWN <b>Mehlville</b> <b>4850</b>  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Anthony Hosp. DOA</b>  |  | Length of stay in lb <b>22</b> STREET ADDRESS <b>1015 Forder Rd</b> (If outside, give location) <b>27</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Ben</b>  |  | 4. DATE OF DEATH<br><b>Sept 23 1957</b>   |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>Jan 28 1904</b>   |  |
| 9. AGE (In years last birthday) <b>53</b>  |  | IF UNDER 1 YEAR <b>7</b> Months <b>26</b> Days IF UNDER 24 HRS. <b>Hours</b> <b>Min.</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt.</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Front Rank Furance Co</b>  |  |
| 11. BIRTHPLACE (City and state or country) <b>St Louis Co. Mo</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |
| 13. FATHER'S NAME <b>Victor Uthoff</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Emelia Benack</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>497-01-8658</b>  |  |
| 17. INFORMANT <b>Mrs Alma Uthoff</b>   |  | Address <b>1015 Forder Rd St Louis 23, Mo.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage (Traumatic)</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Ruptured Aneurysm in the Circle of Willis</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH <b>(None)</b>   |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>330X</b>   |  |   |  |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY: Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____   |  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 20f. CITY, TOWN, OR LOCATION   |  | COUNTY STATE  |  |
| 21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.   |  |   |  |
| 22a. SIGNATURE <b>James J. [Signature]</b> (Type or title)   |  | 22b. ADDRESS <b>21300 [Signature]</b>   |  |
| 22c. DATE SIGNED <b>9/26/57</b>  |  | (State)   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>Sept 27 1957</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>New St Johns Cem</b>   |  | 23d. LOCATION (City, town, or county) <b>Mehlville Mo.</b>  |  |
| 24. FUNERAL DIRECTOR <b>Fey Funeral Home</b> ADDRESS <b>Mehlville Mo.</b>  |  | 25. DATE RECD. BY LOCAL REG. <b>SEP 26 57</b>   |  |
| 26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> S.P.  |  |   |  |

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

