

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011205

FILED APR 10 1959

Registration District No. _____ Primary Registration District No. _____ State File Number 2 3047

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		d. STREET ADDRESS 5572 Bartmer Ave.	
Length of stay in 1b 8 mo.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Elizabeth Middle Last Mohrman			4. DATE OF DEATH Month 3- Day 25 Year 1959		
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5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-1883	9. AGE (In years last birthday) 75	10. UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) Mo.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Chris Kollmer	13b. MOTHER'S MAIDEN NAME Elizabeth Bucklitz	14. NAME OF HUSBAND OR WIFE deceased
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. None	17. INFORMANT Bernice Ferner - 5317 ^e Itaska
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rt. Middle Cerebral Artery Thrombosis		INTERVAL BETWEEN ONSET AND DEATH slab
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral Arteriosclerosis	8 mo.
	DUE TO (c) Generalized Arteriosclerosis	8 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Multiple Dehiscence - 1 mo.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.) 332X
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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
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21. I attended the deceased from 7-28-58 to 3-25-59 and last saw her alive on 3-25-59 Death occurred at 11:40 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) John W. Beckham, M.D.	22b. ADDRESS 5800 Arsenal	22c. DATE SIGNED 3/25/59
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23a. BURIAL, CREMATION, MOVING (Specify) Burial	23b. DATE 3-28-1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Mo
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24. FUNERAL DIRECTOR Edw. Koch & Son - 3576 N. 14th	25. DATE RECD. BY LOCAL REG. MAR 26 '59	26. REGISTRAR'S SIGNATURE Karl Smith, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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REPRODUCED FROM THE MOST COMPLETE SOURCE

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 *W E Morris*

Licensed Embalmer No. *336*
P. O. Address *St Louis*

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.