

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011743  
STATE FILE NUMBER

FILED MAR 30 1959 Registration District No. 317 Primary Registration District No. 548 Registrar's No. 159

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>INDIANA</b> b. COUNTY <b>Spencer</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>WEBSTER GROVES,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Rockport, Ind.</b>
c. FULL NAME OF (If NOT in hospital, give location) <b>Glenwood Home &amp; Hospital</b>		Length of stay in lb <b>96 days</b>	d. STREET ADDRESS (If outside, give location) <b>813 1/2</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>GALDER D. EHRMAN N</b>			4. DATE OF DEATH Month Day Year <b>3 21 59</b>			
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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>6-6-78</b>	9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical Doctor</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>MEDICINE</b>	11. BIRTHPLACE (City and state or country) <b>Indiana</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Edward D. Ehrmann</b>	13b. MOTHER'S MAIDEN NAME <b>Eugenia DeBruler</b>	14. NAME OF HUSBAND OR WIFE <b>Bess Virginia Ehrman</b>
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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. <b>490-46-2528</b>	17. INFORMANT <b>Carl Ehrmann</b>	Address <b>Glendale, Mo. 127 Parkland</b>
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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) <b>unspecified carcinoma of colon</b> <b>--general-arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <b>general arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 mo. -16-yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>general arteriosclerosis</b>		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.)
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20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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 <b>3-21-59</b>	COUNTY	STATE
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21. I attended the deceased from <b>Dec. 16-58</b> to <b>3-21-59</b> and last saw her alive on <b>10:55 A.M.</b> Death occurred at <b>10:55 a.m.</b> 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) <b>W. W. Miller M.D.</b>	22b. ADDRESS <b>1319 Grant Rd. Webster</b>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-21-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Rockport, Ind.</b>
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24. FUNERAL DIRECTOR <b>Parker-Aldrich</b>	ADDRESS <b>Webster Groves</b>	25. DATE RECD. BY LOCAL REG. <b>3-21-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Leslie Welch* .....

Licensed Embalmer No. *4395* .....  
P. O. Address *Hobbs Grove* .....

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.