THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014859

STATE FILE NUMBER

FILED MAY 8 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 23816

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): De Paul Hospital — Length of stay in Hospital: 10 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Berkeley 4000 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 6802 Friarwood — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: ~~Paul~~ PAUL Middle: M. Last: DAUTEN

4. DATE OF DEATH Month, Day, Year: April 17, 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: April 2, 1879

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Luth. Minister

10b. KIND OF BUSINESS OR INDUSTRY: Conc. Pub. House

11. BIRTHPLACE (City and state or country): St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Carl Dautenhahn

13b. MOTHER'S MAIDEN NAME: Johanna Klittich

14. NAME OF HUSBAND OR WIFE: Louise B. Heyer Dauten

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Louis Dauten, Address: 6802 Friarwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 331X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): arteriosclerosis generalized

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 4-8-59, to 4-17-59 and last saw him alive on 4-16-59
Death occurred at 1:00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): M D Johnson M D
22b. ADDRESS: Ferguson Mo
22c. DATE SIGNED: 4-17-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: April 20, 1959
23c. NAME OF CEMETERY OR CREMATORY: St. Trinity Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR ADDRESS: Beiderwieden F.H. Inc., 1936 St. Louis
25. DATE REC'D BY LOCAL REG.: APR 17 '59
26. REGISTRAR'S SIGNATURE: Geo Karl Smith, M.D.

Dr. Mitchell D. Johnson
40 No. Florissant
1-3
7-9

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 452

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failur 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.