Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-023614
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1543

FILED JUN 22 1959

1. PLACE OF DEATH
a. COUNTY St Louis
b. CITY OR TOWN Clayton — Inside Limits Yes # No
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St L Co Hosp — Length of stay in 1b DOA

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY St Louis
c. CITY OR TOWN Overland 426X — Inside Limits Yes # No
d. STREET ADDRESS (If outside, give location) 9216 Lackland — Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First EUGENIA Middle Last WOHLDMANN
4. DATE OF DEATH Month June Day 4 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug 16 1897
9. AGE (In years last birthday) 61 — 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (City and state or country) Florissant Mo
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME John Barteau
13b. MOTHER'S MAIDEN NAME Ozette Benoist
14. NAME OF HUSBAND OR WIFE George Wohldmann
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. None
17. INFORMANT George Wohldmann Address Overland Mo

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arterial hypertension — ?
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

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 6-4-59 to 6-4-59 and last saw her him alive on 6-4-59
Death occurred at 11:45P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE S Paul, MD (Degree or title)
22b. ADDRESS Overland, Mo.
22c. DATE SIGNED 6-5-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 6/8/59
23c. NAME OF CEMETERY OR CREMATORY St Ferdinand
23d. LOCATION (City, town, or county) (State) Florissant Mo

24. FUNERAL DIRECTOR Ortmann F Home ADDRESS 9222 Lackland Overland Mo
25. DATE RECD. BY LOCAL REG. 6-6-59
26. REGISTRAR'S SIGNATURE John G. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 ..A. C. Ortmann.....

Licensed Embalmer No. 3478.....

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.