IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–031029

FILED VS SEP 8 1959

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2318

STATE FILE NUMBER

NDED

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Webster Groves
Length of stay in 1b: 1½ yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 407 Southside
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: St. Louis
c. CITY OR TOWN: Webster Groves
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 407 Southside
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: William Middle: NMI Last: Erman

4. DATE OF DEATH: Month: Aug. Day: 27th Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6-11-1891
9. AGE (last birthday): 68
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Home Remodeling
11. BIRTHPLACE (City and state or country): Keokuk, Iowa
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: John W. Erman
13b. MOTHER'S MAIDEN NAME: Eva M. Schattman
14. NAME OF HUSBAND OR WIFE: Freda Erman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: unk.
17. INFORMANT: Mrs. Freda Erman Address: Above

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) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 1/3 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 2 1/3 yrs
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Bronchial Asthma
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 4-15-57, to 8-27-59 and last saw ~~her~~ him alive on 8-22-59
Death occurred at 10 am 8-27-59 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: B. B. Gummels (Degree or title) M.D.
22b. ADDRESS: 7349 Dale
22c. DATE SIGNED: 8-27-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 8-29-59
23c. NAME OF CEMETERY OR CREMATORY: Hiram Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR: JAY B. SMITH, Maplewood, Mo. ADDRESS
25. DATE RECD. BY LOCAL REG.: 8-28-59
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed H P Burgess

Signature of Student Embalmer

Licensed Embalmer No. 4029

P. O. Address Maplewo

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