

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED OCT 13 1959

59-034114

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 9020**

WENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MO.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b <b>4 DAYS</b>	c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHNS HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1851 CALVIN</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE CASPER MOHRMANN</b>			4. DATE OF DEATH Month Day Year <b>SEPT. 29, 1959</b>			
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>4-24-1885</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NIGHT WATCHMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13a. FATHER'S NAME <b>CASPER MOHRMANN</b>		13b. MOTHER'S MAIDEN NAME <b>MARY JOLLY</b>		14. NAME OF HUSBAND OR WIFE <b>JULIA MOHRMANN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>189 05 0473</b>		17. INFORMANT Address <b>DOROTHY WEISMILLER 1075 ERMANDA DR.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b>			<b>7 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Perforated duodenal ulcer.</b>		<b>4 days</b>
	DUE TO (c) <b>Hemorrhage into bowel.</b>		<b>12 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Peritonitis due to Perforation - A.S. CV disease</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <b>491 X</b>
20c. TIME OF INJURY Hour Month, Day, Year 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
21. I attended the deceased from <b>Sept 25 1959</b> to <b>Sept 29 1959</b> and last saw him alive on <b>Sept 28 1959</b> Death occurred at <b>7:15 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <b>Dr G A Lindeman M.D.</b>		22b. ADDRESS <b>4126: Sheran Ave</b>	22c. DATE SIGNED <b>9/29/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>OCT. 2, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>S S PETER &amp; PAUL CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, MO.</b>

24. FUNERAL DIRECTOR ADDRESS <b>STROTT CARROLL 4600 NATURAL BRIDGE</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 1 59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

278 B

**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 M. W. Rueter

Licensed Embalmer No. 4865

P.O. Address St Louis, Mo

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.