

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318 1003

387562-016844
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED APR 25 1962

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE		b. COUNTY	3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR				
St. Louis		St. Louis			Missouri		St. Louis		Paul Craig Hamann		4 11 62		Male		White		10/5/98		63		Months		Days		Hours		Min.	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>																		
Barnes Hospital						6416 Woodrow Ave		20																				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (City and state or country)					12. CITIZEN OF WHAT COUNTRY								
Retired Electrician										Electrical					St. Louis Missouri					U.S.A.								
13a. FATHER'S NAME					13b. MOTHER'S MAIDEN NAME					14. NAME OF HUSBAND OR WIFE																		
William F. Hamann					Lena Craig					Mrs. Gail Hamann																		
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.					17. INFORMANT Address													
No										None					Mrs. Gail Hamann 6416 Woodrow Ave. 20													
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH																		
IMMEDIATE CAUSE (a)										few hours																		
Auto myocardial infarction																												
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b)																		
										Old myocardial infarction																		
										DUE TO (c)																		
										Coronary occlusion. 4201																		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										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 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.)																				
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year																										
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 July 1942 to time of death and last saw him alive on 4-6-62 Death occurred at 9:30 AM m on the date stated above, and to the best of my knowledge, from the causes stated.																												
22a. SIGNATURE Charles T. Duder M.D.					(Degree or title)					22b. ADDRESS 3720 Washington Ave.					22c. DATE SIGNED 4-12-62													
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)						(State)													
Cremation			4/14/62			Valhalla Chapel of Memories			St. Louis County Missouri																			
24. FUNERAL DIRECTOR Calvin F. Feutz 4828 Nat'L Bridge Blvd.										25. DATE RECD. BY LOCAL REG. APR 14 1962					26. REGISTRAR'S SIGNATURE Earl Smith, M.D.													

Chas. M. Dickson
3720 Washington
Je 3-4511

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 Robert E. Mathman

Licensed Embalmer No. 4916

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.