MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

19462

1. PLACE OF DEATH

County ..... Registration District No. 791 ..... File No. 5052

Township ..... Primary Registration District No. 1005 ..... Registered No. .....

City St. Louis (No. Racquet Club ..... St. ..... Ward)

2. FULL NAME August C. Lueking

(a) Residence. No. 7130 Westmoreland St., 12 Ward. St. Louis Co

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Cornelia R. Lueking

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 12-1866

7. AGE: 63 YEARS, 4 MONTHS, 29 DAYS. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Member of Board of Directors

(b) General nature of industry, business, or establishment in which employed (or employer): Ely-Walker Dry Goods Company

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): St. Louis

(STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Herman H. Lueking

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Germany

12. MAIDEN NAME OF MOTHER: Anna R. Mener

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Germany

14. INFORMANT: J. C. Raymond

(Address) 7130 Westmoreland Drive St. Louis

15. FILED ..... 1929 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): ~~April~~ May 1 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1929, to ~~April~~ May 1, 1929 that I last saw him alive on April 24, 1929, and that death occurred, on the date stated above, at 6 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Angina Pectoris

94 P.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? —

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No DATE OF —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory

(Signed) Arthur E. Shaw, M.D.

5/2, 1929 (Address) Univ. Club Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: St. John's Cemetery

DATE OF BURIAL: May 4 1929

20. UNDERTAKER: Wagoner

ADDRESS: 3621 Olive

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

10 — 1533