

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

Do not use this space.

41599

File No. 262  
Registered No. 170262  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**1. PLACE OF DEATH**

County St. Louis Registration District No. 1170  
Township Central Primary Registration District No. 6248  
City Richmond Mo. (No. St. Marys Hospital)

**2. FULL NAME**

Mrs. Rose Lehman  
(a) Residence. No. 2128 1/2 University St. Ward. St. Louis, Mo.  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Eduard Lehman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 10 1894

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>39</u>	<u>-</u>			

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housewife 235  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) St. Louis Mo  
(STATE OR COUNTRY)

10. NAME OF FATHER Unk 31

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) Unk

12. MAIDEN NAME OF MOTHER Unk

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) Unk

14. INFORMANT Thomas Finan  
(Address) 1519 So Grand

15. FILED \_\_\_\_\_, 19 \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 17 1932  
17.  I HEREBY CERTIFY, That I attended deceased from Dec 3, 1932, to Dec 17, 1932  
that I last saw h. or alive on Dec 16, 1932, and that death occurred, on the date stated above, at 8 AM m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pneumonia  
108  
130  
(duration) \_\_\_\_\_ m. da.

CONTRIBUTORY (SECONDARY) Acute nephritis  
(duration) \_\_\_\_\_ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH: 2528 W. Quincy

19. DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? No

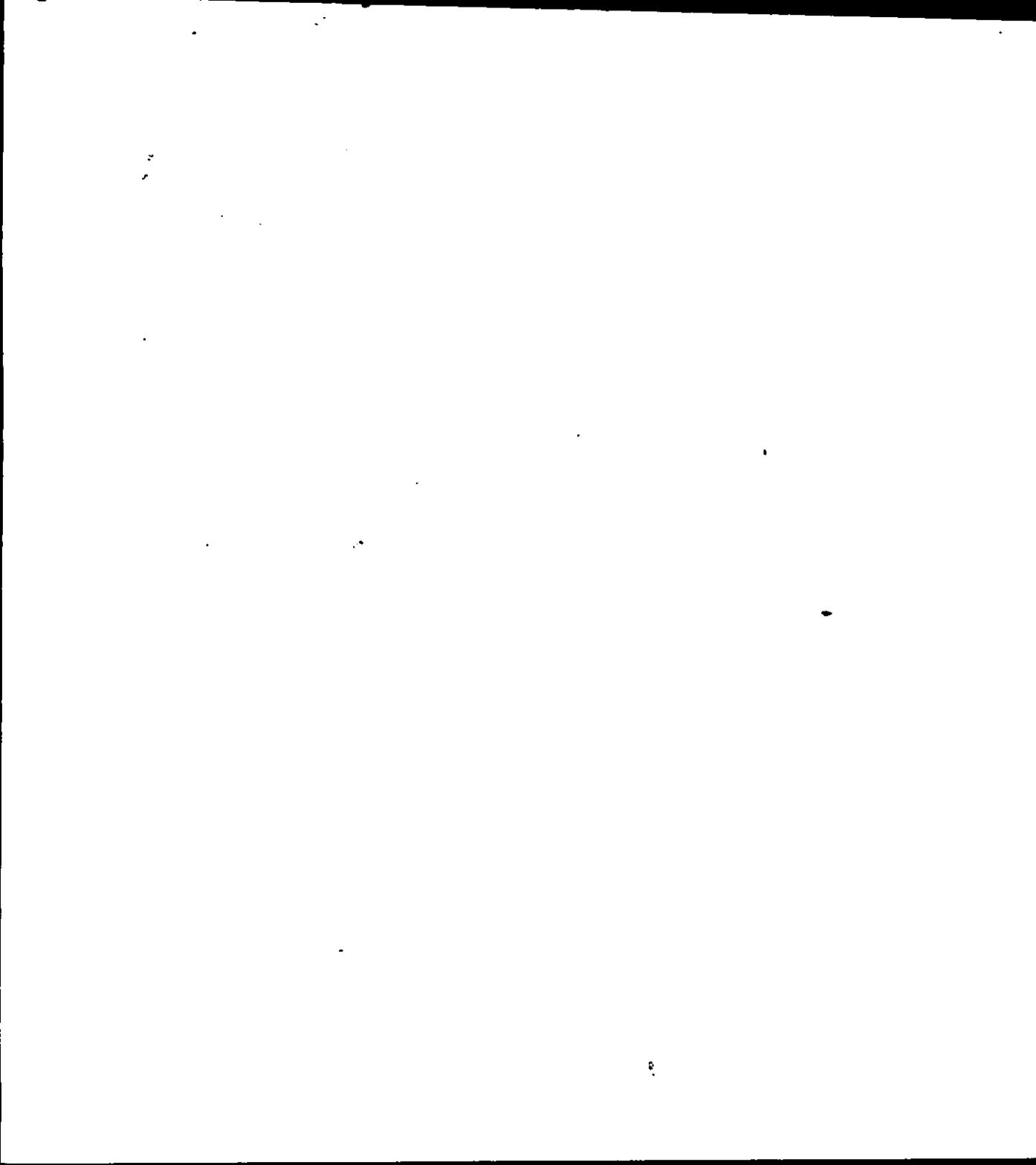
WHAT TEST CONFIRMED DIAGNOSIS? Algebra  
(Signed) James E. [Signature]  
12/17/32 (Address) 1004 W. [Address]

\*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 Calvary Cemetery DATE OF BURIAL 12-19 1932

20. UNDERTAKER Thos. Finan ADDRESS 1519 So Grand

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.



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County.....

Registration District No. 1170

Township.....

Primary Registration District No. 6248

Richmond Heights (No. ....)

File No. ....

Registered No. 762

St. .... Ward.....

**2. FULL NAME**

Rose Lehman

(a) Residence, No. .... St. .... Ward.....

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER  
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED Dec. 18 1932 Roll. J. Ambrose Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/17 1932

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him alive on ..... 19..... Death is said

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

**SUPPLEMENTARY**

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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