

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.

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

Do not use this space.

JUN 12 1935

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1. PLACE OF DEATH

County.....  
Township.....  
City..... *St Louis* (No. *4629*, *Route Ave*)

Registration District No.....  
Primary Registration District No.....

File No.....  
Registered No. **4803**  
St..... Ward.....

2. FULL NAME

*John F. Lenkman Jr.*

(a) Residence, No. *4629 Route* St. *7* Ward.

(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) *Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *12-25-1912*

7. AGE YEARS *22* MONTHS *5* DAYS *5* If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Grocer*  
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) *St Louis Mo*

FATHER 13. NAME *John F. Lenkman*

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

MOTHER 15. MAIDEN NAME *Margaret Gauding*

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

17. INFORMANT (ADDRESS) *John F. Lenkman 4629 Route Ave*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Calvary* DATE *6-3-* 1935

19. UNDERTAKER (ADDRESS) *H. A. Strickland & Co 2117 E. Grand Blvd*

20. FILE NO. *MAY 31 1935*

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 30* 1935

22. I HEREBY CERTIFY, That I attended deceased from *MAR 29*, 1935, to *MAY 30*, 1935  
I last saw him alive on *May 30*, 1935. Death is said to have occurred on the date stated above, at *12:30* a.m.

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

*SARCOMA*  
*10th RIBS (RT SIDE)*  
*BRUISES OF RIBS*  
*RT SIDE*  
Date of onset *Feb 35*

Other contributory causes of importance:  
Name of operation *yes* Date of *APR 16*  
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 *Accident* Date of injury *Feb 35*  
Where did injury occur? *St Louis Mo*  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. *In Home*  
Manner of injury *Bruise of Ribs*  
Nature of injury *fell down stairs*

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify *Yes*  
(Signed) *James J. Milk*, M. D.  
(Address) *444 W. Johnson*

Colfax 2783

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County \_\_\_\_\_  
Township \_\_\_\_\_  
City St. Louis

Registration District No. 791  
Primary Registration District No. 1003

File No. \_\_\_\_\_  
Registered No. 4803  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

John F. Lenkman, Jr.  
(a) Residence, No. 4629 Route 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 W 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S.

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.  
22 5 5

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_

19. UNDERTAKER (ADDRESS)

20. FILED 6/19 1935 J. F. Bredest  
Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 30, 1935

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_ to \_\_\_\_\_, 19\_\_

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_ Death is said

to have occurred on the day 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**

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

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