

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

32354

Do not use this space.

1. PLACE OF DEATH

(a) County _____ Registration District No. **791**
(b) Township _____ Primary Registration District No. **1003**
(c) City **St. Louis** (d) Street No. **5461 Delor St.** St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **8408**

2. PRINT FULL NAME **William A. Luft**

(a) Residence, No. **5461 Delor St.** St. **14**
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 11th 1859**

7. AGE YEARS **78** MONTHS **2** DAYS **23** If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **retired**
9. Industry or business in which work was done, as saw mill, bank, etc. **Harness Maker**
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

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

FATHER 13. NAME **Henry Luft**

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

MOTHER 15. MAIDEN NAME **Kuechler**

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

17. INFORMANT **Sophia Luft** (ADDRESS) **5461 Delor St.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **New St. Marcus** DATE **9/8/37**

19. FUNERAL DIRECTOR **J. L. Ziegenhein & Sons** (ADDRESS) **7027 Gravois Ave**

20. FILED **SEP 7 1937** **J. F. Brebeck** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9-4** 19**37**

22. I HEREBY CERTIFY, That I attended deceased from **July 30**, 19**37**, to **Sept 4**, 19**37**
I last saw him alive on **Sept 4th**, 19**37**. Death is said to have occurred on the date stated above, at **6:15 P M**
The principal cause of death and related causes of importance were as follows:

lethargic Encephalitis Date of onset **May 30**

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? **No**

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? **No**
If so, specify _____
(Signed) **Wm. B. Gagner**, M. D.
(Address) **3014 S. Jefferson**

STATEMENT BY LICENSED EMBALMER

I, I. C. P. Kidwell, Licensed Embalmer No. 3877

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed

Clarence P. Kidwell

Licensed Embalmer No. 3877

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.)