

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.

OCT 4 1937

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

32822
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. **St. John's Hospital** 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. **8876**

2. PRINT FULL NAME **Henry J. Lechner**
(a) Residence, No. **4120 E. Iowa Ave.** St. **15**
(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 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 Cecilia Lechner				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 30, 1897.				
7. AGE 40	YEARS	MONTHS 5	DAYS 23	If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Mechanic				
9. Industry or business in which work was done, as saw mill, bank, etc. Public Service Co.				
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, Co.**
(STATE OR COUNTRY) **Mo.**

13. NAME **Joseph Lechner**

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

15. MAIDEN NAME **Dont Know.**

16. BIRTHPLACE (CITY OR TOWN) **Dont Know.**
(STATE OR COUNTRY)

17. INFORMANT **Cecilia Lechner**
(ADDRESS) **4120 E. Iowa Ave/**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **Arnold, Mo.** DATE **Sept. 25, 1937.**

19. FUNERAL DIRECTOR **J. N. Gubken & Co.**
(ADDRESS) **2842 Meramec St.**

20. FILE **SEP 23 1937**
Breck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 22, 1937	
22. I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1937 to Sept. 22, 1937 I last saw him alive on Sept. 22, 1937 Death is said to have occurred on the date stated above, at 9:00 P. m. The principal cause of death and related causes of importance were as follows: Carcinoma of Liver Primary HO 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) R. H. Gubken , M. D. (Address) 2901 S. Park Ave	

STATEMENT BY LICENSED EMBALMER

I, Herman A. Gebken, Licensed Embalmer No. 2120

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

Herman A. Gebken

Licensed Embalmer No. 2120.

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.)