

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 34726Registration District No. 1008

Primary Registration District No. _____

Registrar's No. 9264

1. PLACE OF DEATH:

(a) County BECD NOV 13 1939
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: City Hosp #1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community Life years, months or days)

3. (a) PRINT FULL NAME Sophie Lohmeyer 5623. (b) If veteran, name war Nil 3. (c) Social Security No. Nil4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

7. Birth date of deceased Feb 2 1872
(Month) (Day) (Year)8. AGE: Years 64 Months 8 Days 26 If less than one day
hr. _____ min. _____9. Birthplace Illinois (City, town, or county) (State or foreign country)10. Usual occupation School Teacher (Retired)

11. Industry or business _____

MOTHER FATHER
 12. Name William Lohmeyer
 13. Birthplace Germany (City, town, or county) (State or foreign country)
 14. Maiden name Louise Larsenick
 15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own name Eather Kuhlman(b) Address 1810 Lawrence Ave17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30th. (Month) (Day) (Year)(c) Place: burial or cremation St. Peters Cemt.18. (a) Signature of Barrigan & Sheahan Und Co(b) Address 4415 Washington Blvd.19. (a) OCT 30 1939 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
 (c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
 (d) Street No. 1810 Lawrence Ave (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 28
year 1939 hour 8 minute 50 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of right hip, Arteriosclerosis; suffered in fall to floor in her home 1810 Lawrence Av., August 29th 1939, about 8.00 o'clock P.M., ACCIDENT. Duration _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ACCIDENT(b) Date of occurrence AUGUST 29, 1939.(c) Where did injury occur? St. Louis, Mo. (City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature Joseph H. DeLeon (M. D. or other) _____Address Deputy Coroner

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Homer W. Fritz

Licensed Embalmer No. *3882*

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.