

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 38183
Registrar's No. 10022DEC 17 1939 791
Registration District No. 791

Primary Registration District No. _____

1. PLACE OF DEATH: 1008

(a) County _____ 1

(b) City or town St. Louis,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Bethesda Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution One week
(Specify whether _____)

In this community Life time
years, months or days

3. (a) PRINT FULL NAME Eunice S. Lutz, 320

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. 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 alive _____ years

7. Birth date of deceased April 9th 1873
(Month) (Day) (Year)

8. AGE: Years 66 Months 7 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Public school teacher.

11. Industry or business 0

MOTHER FATHER { 12. Name Albert Lutz 1

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Rebecca C. Staples

15. Birthplace Penn
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wagoner Und. Co.

(b) Address Los Angeles Calif.

17. (a) cremation (b) Date thereof. Nov. 24, 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory.

18. (a) Signature of funeral director Wagoner Und. Co.

(b) Address 3621 Olive St.

19. (a) NOV 24 1939 (b) J. F. [Signature]
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County _____

(c) City or town St. Louis, 12
(If outside city or town limits, write "RURAL")

(d) Street No. 5315 Pershing Ave.,
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 21st
year 1939 hour 7 minute 15 M.

21. I hereby certify that I attended the deceased from Jan 1936
Jan 1939, to Nov 21 1939.

that I last saw her alive on Nov - 21 - 1939
and that death occurred on the date and hour stated above

Immediate cause of death General Metastatic Carcinomatosis. ^{Duration}

Due to In Jan. 1936 Right Breast Was Amputated

Due to Carcinoma

Other conditions 50
(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) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature [Signature] (M. D. or other)

Address 4500 Olive St. Date signed 12/29/39

*Don't let it go
45 to 6 line
2. 1. 1. 1.*

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 *Neville E. Frohwitter*
Licensed Embalmer No. *3696*
P. O. Address *3621 Olive St.*

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.