

JUN 15 1940

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

4559

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Anthony's Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_  
(c) City or town St. Louis 15  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4407 Pennsylvania  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Ottilie Lamack 526

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Mar.

6. (b) Name of husband or wife August Lamack 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Jan. 10, 1883  
(Month) (Day) (Year)

8. AGE: Years 57 Months 4 Days 11 hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation housework

11. Industry or business at home

12. Name Marie Potthast

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

14. Maiden name Margine Driehle

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

16. (a) Informant August Lamack

(b) Address 4407 Pennsylvania

17. (a) Burial (b) Date thereof 5-24-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cem.

18. (a) Signature of funeral director Southern Ind. Co.

(b) Address 2 Grand

19. (a) MAY 23 1940  
(Date received local registrar)

(b) Signature J. B. Brubaker

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21st  
year 1940 hour \_\_\_\_\_ minute 11 p. M.

21. I hereby certify that I attended the deceased from Feb 8  
28 1940 to May 21 1940

that I last saw him alive on May 21 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Heart Failure 1 week  
chronic myocarditis

Due to New growth of tumor unknown  
(lower lobe) probably

Due to malignant

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy none

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 Robert J. Warr (M. D. or other) \_\_\_\_\_  
Address Paul Brown Bldg. Date signed May 22 1940

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

818 Oline

Dr. Warner  
Paul Brown  
tel. - 1-30

1115

**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 Virgil L. Berryman  
Licensed Embalmer No. 14018  
P. O. Address St. Louis Mo.

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.