

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

26915

State File No. _____

Registration District No. **791** Primary Registration District No. **1003** Registrar's No. **6811**

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:
3134 LAFAYETTE AV. 2
(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) _____

3. (a) PRINT FULL NAME GEORGE LUEPKE
3. (b) If veteran, name war WORLD WAR. 3. (c) Social Security No. _____

4. Sex MALE 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 OCTOBER 10 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
47 | 9 | 30 | _____ hr. _____ min.

9. Birthplace ST. LOUIS MO. O
(City, town, or county) (State or foreign country)

10. Usual occupation STREET DEPT. CITY

11. Industry or business _____

12. Name John LUEPKE

13. Birthplace ST. LOUIS MISSOURI O
(City, town, or county) (State or foreign country)

14. Maiden name LOUISE MAES.

15. Birthplace ST. LOUIS MISSOURI O
(City, town, or county) (State or foreign country)

16. (a) Informant William Luepke

(b) Address 7523 Melrose Av

17. (a) BURIAL (b) Date thereof AUG. 12 1940
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NATIONAL CEM. JEFFERSON, MO

18. (a) Signature of funeral director E. J. Schurr, DARRACKS

(b) Address 3125 Lafayette Ave

19. (a) AUG 11 1940 (b) J. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS 17
(If outside city or town limit, write "RURAL")
(d) Street No. 3134 LAFAYETTE AV.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 9
year 1940 hour 13 00 minute A. M.

21. I hereby certify that I attended the deceased from 2-1-1940 to 8-9-40, 1940,
that I last saw him alive on 8-2-40, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis
Due to arterio sclerosis
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN [Signature]
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? _____

(Specify type of place) _____
(e) Means of injury _____
Signature [Signature] (M. D. or other) _____
Address 3604 Delange Date signed 8-10-40

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

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

Jos B Vollmer

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette Ave*

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.