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DM-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30141

State File No. _____

Registrar's No. **8225**

Registration District No. **1818**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
Mo. Baptist Hospital
(If not in hospital or institution, write street number or location) **0**

(d) Length of stay: In hospital or institution 2 months
(Specify whether _____)

In this community Life
years, months or days)

3. (a) PRINT FULL NAME John W. Lehmann

3. (b) If veteran, name war _____

3. (c) Social Security No. 493-10-5422

4. Sex Male **5. Color or race** White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Kathryne Lehmann

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased March 23 1887
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>56</u>	<u>5</u>	<u>21</u>	hr. _____ min.

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

10. Usual occupation Security Salesman

11. Industry or business _____

12. Name Charles Lehmann

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

14. Maiden name Unknown

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

16. (a) Informant Kathryne Lehmann

(b) Address 4818 Palm St.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Sept. 17 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine

18. (a) Signature of funeral director Calvin Feutz Funeral Home

(b) Address 4828 Nat'l Bridge Bl.

19. (a) SEP 15 1943 (Date received local registrar)

(b) J.F. Bredek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missiouri (b) County _____

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

(d) Street No. 4818 Palm St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 14th 1943
year 1943 hour 10:00 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from August 1942 to Sept. 14 1943
that I last saw him alive on Sept. 14 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic heart disease with aortic insufficiency

Duration 20 yrs

Due to _____

Due to 95

Other conditions (include pregnancy within 3 months of death) _____

Major findings:

Of operations _____

Of autopsy not permitted

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 John L. Horner (M. D. or other) M.D.

Address 114 N. Taylor **Date signed** 9-15-43

844 (Licensed Embalmer's Statement on Reverse Side)

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 John A. Mlesna.....
Licensed Embalmer No. 4186.....

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, fact should be so stated above.