No. 2
—5-43
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 9 1943

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36632

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10362

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: St. Louis Children's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 hrs. 45 min. (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 92 7 20

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

(d) Street No. 2500 Benton
(If rural, give location)

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

If yes, name country 1

3. (a) PRINT FULL NAME Willa May Lutes

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 Child

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 26 (Day) 1942 (Year)

8. AGE: Years 1 Months 6 Days 6 If less than one day hr. min.

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

10. Usual occupation Child

11. Industry or business

FATHER 12. Name Samuel Lutes

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

MOTHER 14. Maiden name Leona Dixon

15. Birthplace High Hill, (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Samuel Lutes

(b) Address St. Charles, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/43 (Month) (Day) (Year)

(c) Place: burial or cremation St. Charles, Mo.

18. (a) Signature of funeral director Albert H. Hoppe Inc.

(b) Address 4700 Washington Blvd.

19. (a) NOV 26 1943 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 26 year 1943 hour 4 minute 45 A.M.

21. I hereby certify that I attended the deceased from 11-25-43, 19..., to 11-26-43, 19...; that I last saw her alive on 11-26-43, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Leukemia	
Due to:	
Due to:	
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)

(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)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

(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 Ogonoski

Licensed Embalmer No. 2398

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, fact should be so stated above.