

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 27274

FILED AUG 23 1944

Registration District No. 42Primary Registration District No. 1000Registrar's No. 839

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St. Joseph
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Mo. Methodist Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 hours
 (Specify whether
 In this community 56 years
 years, months or days)

3. (a) PRINT FULL NAME ARTHUR L. LEHR

3. (b) If veteran, name war none
 3. (c) Social Security No. 488-14-6465

4. Sex male 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Aage Hannah Lehr
 6. (c) Age of husband or wife if alive 62 years
 7. Birth date of deceased September 4 1881
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>11</u>	<u>10</u>	hr. _____ min.

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

10. Usual occupation construction

11. Industry or business Lehr Construction Co.

12. Name James W. Lehr
 13. Birthplace Bremen Indiana
 (City, town, or county) (State or foreign country)
 14. Maiden name Helen Sharp
 15. Birthplace unknown Kansas
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Arthur L. Lehr
 (b) Address 2671 Fairleigh Place

17. (a) burial (b) Date thereof 8/16/44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Jo. Mem. Park Cem.

18. (a) Signature of funeral director Walter B. Balle & Bowman
 (b) Address 310 South 10th

19. (a) 8/16/44 (b) Walter Balle
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2671 Fairleigh Place
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 14
 year 1944 hour _____ minute 9 P. M.

21. I hereby certify that I attended the deceased from July 8
1944 to Aug 14 19 44
 that I last saw him alive on _____ 19 _____
 and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured aorta
 Due to Dissecting Aorta
Cerebral 157
 Due to _____

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations ADDITIONAL
SUPPLEMENTARY
 Of autopsy INFORMATION
REQUESTED

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)
 (c) Means of injury 0

23. Signature Dr. J. J. ... (M. D. or other) MD
 Address St. Joseph, Mo Date signed 8-15-44

1397

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. L. N. Fudson
Kirkpatrick Bldg.

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 Frank A. Courman

Licensed Embalmer No. 1710

P. O. Address St. Joseph W.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept
Registrar's No. 852

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(c) Name of hospital or institution:
(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 Arthur S. Lehr
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced..... m

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... 45 year

7. Birth date of deceased Sept 7 (Month) (Day) (Year)

8. AGE: Years 62 Months 11 Days 10 If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug Day 14 Year 1944 Hour 10 minute 4 M.
21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to Not Septicemia 96
Due to.....

Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations.....
Of autopsy.....
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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?

23. Signature Dr. Dawson (M. D. or other)
Address..... Date signed.....
(Specify type of place) (c) Means of injury

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

SUPPLEMENTARY

27274