

FILED SEP 30 1944 318

Registration District No. _____ Primary Registration District No. _____

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: Barnes Hospital,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 32 day (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME LILLIAN ANNA LEHDE

3. (b) If veteran, name war None 3. (c) Social Security No. Unknown

4. Sex Female 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 July 6 1902
(Month) (Day) (Year)

8. AGE: Years 42 Months 2 Days 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name John Lehde
13. Birthplace Washington County Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Minnie Rebbe
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant George Sasse
(b) Address Shobonier, Ill.

17. (a) Removal (b) Date thereof 9-23-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Augsburg, Illinois

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) SEP 26 (b) J. B. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison
(c) City or town Edwardsville
(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 9 day 22
year 1944 hour 9 minute 10 a.m.

21. I hereby certify that I attended the deceased from September
August 21, 1944, to September 22, 1944
that I last saw her alive on September 22, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tbc, left Duration 3 yrs.

Due to _____
Due to _____

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

Major findings: Of operations Pulmonary Tbc, left
Of autopsy Pulmonary Tbc, left. 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 M. C. Adney (M. D. or other) _____
Address Barnes Hospital Date signed 9-22-44

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

1179

99
110
NR

MOTHER FATHER

844

8205

8205

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.....

Albert G. Hoppe

..... Licensed Embalmer No. 2971.....

..... 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.