

FILED DEC 9 1944

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10279**

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

1. PLACE OF DEATH:

(a) County St. Louis Mo  
 (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:  
Lutheran Hosp  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 4971a Magnolia Ave  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lucille Hutfless

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Joseph A 6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased Nov 26 1905  
(Month) (Day) (Year)

8. AGE: Years 39 Months 0 Days 4 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housework

11. Industry or business at Home

12. Name William Bochnieck

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

14. Maiden name May Unknown

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

16. (a) Informant Joseph A Hutfless

(b) Address 4971a Magnolia Ave

17. (a) Burial (b) Date thereof 12 4 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old. S.S. Peter Pau

18. (a) Signature of funeral director KRIEGSHAUSER

(b) Address 4228 So. Kingshighway

19. (a) DEC 2 1944 (b) J. Bochnieck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 1  
 year 1944 hour 2 minute 50 A.M.

21. I hereby certify that I attended the deceased from Nov. 1  
1944 to DEC. 1, 1944  
 that I last saw h ER alive on Nov. 30, 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Hodgkins Disease Duration 6 mo

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 Arnold Splin (M. D. or other) M.D.  
 Address 2632 So. Kingshighway Date signed 12/1/44

---

---

**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 Edwin D Mc Dermott

Licensed Embalmer No. 3024

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.**