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

#20153

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 29 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39573

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10841

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 720 So. 2nd St.,
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Joseph Lueckemeier

3. (b) If veteran, name war unk

3. (c) Social Security No. unk

4. Sex male

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 Nov. 25th, 1869
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
75	0	23	hr. min.

9. Birthplace Germany (City, town, or county) 4 (State or foreign country)

10. Usual occupation Laborer

11. Industry or business unemployed

FATHER
12. Name Anthony
13. Birthplace Germany (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Mary Osterman
15. Birthplace Germany (City, town, or county) 4 (State or foreign country)

16. (a) Informant M. Renard
(b) Address St. Louis City Hospital

17. (a) Cremation (b) Date thereof 12-21-44
(Month) (Day) (Year)

(c) Place: [redacted] cremation City Crematory

18. (a) Signature of funeral director W. T. White
(b) Address City Hospital No.

19. (a) DEC 20 1944 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18th
year 1944 hour 4:40 minute A. M.

21. I hereby certify that I attended the deceased from 12/13/44
, 19 , to Dec. 18th, 19 44
that I last saw him alive on Dec. 18th, 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)
Generalized Arteriosclerosis

Major findings:
Of operations

Of autopsy

Duration

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 J. F. Trout (M. D. or other)
Address 1515 Lafayette Date signed 12/18/44

(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.....

Licensed Embalmer No.....

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.