

S. No. 2  
DM-5-42  
v. 5-17-39  
I X32873

35564

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. ....

Registrar's No. ....

**FILED DEC 7 1945**  
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....  
(b) City or town. St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. John's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 7 Weeks  
(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. 5627 A.S. Kingshighway  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Robert J. Lucas  
3. (b) If veteran, name war. \*\*\*\*\*  
3. (c) Social Security No. ....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month. 28th day November  
year 1945 hour 6:00 minute P.M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced, Widower  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased. April 21 1870  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct. 31, 1945, to Nov. 28, 1945, that I last saw him alive on Nov. 28, 1945, and that death occurred on the date and hour stated above.  
Immediate cause of death Acute Lymphatic Leukemia. Duration.....

8. AGE: Years Months Days If less than one day  
75 7 7 hr. min.

Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)  
Autopsy: Bronchiectasis. Broncho Pneumonia. Cirrhosis of Liver. Splenomegaly

9. Birthplace. Pennsylvania (City, town, or county) (State or foreign country)  
10. Usual occupation. Chief Engineer

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
Autopsy: Bronchiectasis. Broncho Pneumonia. Cirrhosis of Liver. Splenomegaly

MOTHER FATHER  
11. Industry or business. Falstaff Brewing Co.  
12. Name. Robert J. Lucas  
13. Birthplace. England (City, town, or county) (State or foreign country)  
14. Maiden name. Elizabeth Mills  
15. Birthplace. England (City, town, or county) (State or foreign country)

16. (a) Informant. Paul Clostermayer  
(b) Address 5627 A.S. Kingshighway  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof. Dec 1 1945 (Month) (Day) (Year)  
(c) Place: burial or cremation New St. Marcus Cemetery

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?.....

18. (a) Signature of funeral director. J. J. ...  
(b) Address. 6419 Gravois Ave.  
19. (a) NOV 30 1945 (Date received local registrar) (b) J. J. ... (Registrar's signature)

While at work? (Specify type of place) (c) Means of injury.....  
23. Signature. J. J. ... (M.P. or other)  
Address 3720 Washington Blvd. Date signed 11/30.

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

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*Dr. J. H. Beckman  
Beaman Embalming*

*Je. 3600  
1703*

**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 *Homer Futz*.....

Licensed Embalmer No. *3882*.....

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.**