

S. No. 2  
 M-5-43  
 v. 5-17-39  
 P I X3877

**FILED MAY 27 1946**  
 Registration District No. **318**

Primary Registration District No. **1003**

**1. PLACE OF DEATH:**  
 (a) County St. Louis  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Missouri Baptist Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County 94  
 (c) City or town Meadowbrook  
(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 \_\_\_\_\_

**3. (a) PRINT FULL NAME** Josirah Lutman  
**3. (b) If veteran,** name war No **3. (c) Social Security No.** Unknown  
**4. Sex** Male **5. Color or race** White  
**6. (a) Single, widowed, married, divorced** Widower  
**6. (b) Name of husband or wife** Lucy **6. (c) Age of husband or wife if alive** \_\_\_\_\_ years  
**7. Birth date of deceased** Sept. 10 1874  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month May day 12 year 1946 hour 2 minute 35 P. M.  
**21. I hereby certify that I attended the deceased from** 5/5, 1946, to 5/12, 1946, that I last saw him alive on 5/12, 1946, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>8</u>	<u>2</u>	_____ hr. _____ min.

Immediate cause of death  
Acute Fibrillation myocarditis  
 Duration 6 yrs 10 yrs  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Hypertrophied Prostate  
(Include pregnancy within \_\_\_\_\_ months of death)

**9. Birthplace** Doe Run Missouri  
(City, town, or county) (State or foreign country)  
**10. Usual occupation** Laborer  
**11. Industry or business** \_\_\_\_\_  
**12. Name** William Lutman  
**13. Birthplace** Unknown  
(City, town, or county) (State or foreign country)  
**14. Maiden name** Mary Ann Link  
**15. Birthplace** Elvins Missouri  
(City, town, or county) (State or foreign country)  
**16. (a) Informant** Clarence Jones  
**(b) Address** 2620 S. Broadway  
**17. (a) Burial** Desloge, Mo. **(b) Date thereof** 5-15-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** \_\_\_\_\_  
**18. (a) Signature of funeral director** Albert H. Hoppe  
**(b) Address** 4706 Washington Blvd.  
**19. (a) MAY 13 1946 **(b) J. F. Brodeur**  
(Date received local registrar) (Registrar's signature)**

**PHYSICIAN**  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**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** J. F. Brodeur (M. D. or other)  
**Address** 607 N. Grand **Date signed** 5/13/46

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

17537

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**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 Elmer R. Padwell  
Licensed Embalmer No. 4077  
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.**