

S. No. 2
 OM-542
 v. 5-17-39
 X32873

32332

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No.

FILED SEP 30 1946

1003

Registrar's No. 8137

Registration District No. Primary Registration District No.

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:
Lutheran Hospital 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(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..... **5053 Miami St.**
(If rural, give location)
 (e) Citizen of foreign country?.....
(Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **Sophie Wells**
 3. (b) If veteran, name war.....
 3. (c) Social Security No.....

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Sept.** day **20**
 year **1946** hour **8** minute **A.** M.

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Joseph**
 6. (c) Age of husband or wife if alive **59** years
 7. Birth date of deceased **Aug. 3 1890**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **1-8** 19**46** to **9-20** 19**46**
 that I last saw her alive on **9-20** 19**46**
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	56	1	17	hr. min.

Immediate cause of death.....
Coronary embolus
 Due to **myocardial failure** 6 mos
 Due to **generalized carcinoma** 1 year
 Other conditions **carcinoma** 1 year
(Include pregnancy within 3 months of death)
bladder/urinary

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Housewife**
 11. Industry or business.....

Major findings:
 Of operations **ca of bladder**
Primary site in bladder
 Of autopsy.....
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER {
 12. Name..... **William F. Lahmann**
 13. Birthplace **Marine Illinois**
(City, town, or county) (State or foreign country)
 14. Maiden name **Sophie Blum**
 15. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)
 16. (a) Informant **Joseph Wells**
 (b) Address **5053 Miami St.**
 17. (a) **Burial** (b) Date thereof **9/23/46**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **O. SS Peter & Paul**
 18. (a) Signature of funeral director **Wacker-Hilde**
 (b) Address **3634 Gravois Ave.**
 19. (a) **SEP 21 1946** (b) **W. Hilde**
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury
 23. Signature..... **Wacker-Hilde** (M. D. coroner)
 Address **3651 Grand St** Date signed **9-21-46**

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

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..... *T. Rosen Wheeler*

Licensed Embalmer No..... *2178*

P. O. Address..... *[Signature]*

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.