

S. No. 2  
FORM-5-43  
Rev. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 3046

**FILED** Oct 21 1946

Registration District No. 267 Primary Registration District No. 3069

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Mary 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 \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis 96

(c) City or town Mattese  
(If outside city or town limits, write "RURAL")

(d) Street No. R 8 Box 783  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Martin Lammert

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 10  
year 1946 hour 1 minute 05 M.

4. Sex Male 5. Color or White

6. (a) Single, widowed, married, Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Sept 20 1946  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 7 1946 to Oct 9 1946  
that I last saw her alive on Oct 9 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 20  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Broncho pneumonia Duration 2 days

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

Due to: malformation of larynx

Due to: 157. M.

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation \_\_\_\_\_

11. Industry or business None

12. Name: Frank Lammert

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

14. Maiden name: Heln Scherrer

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

16. (a) Informant: Frank Lammert

(b) Address: Mattese Mo.

17. (a) burial (b) Date thereof: 10/12/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Fendler Und Co  
7420 Michigan Ave

Major findings: Tracheostomy

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

18. (a) Signature of funeral director: Accomplices Church Mattese

(b) Address: \_\_\_\_\_

19. (a) 10-17-46 (b) Ruth J. Galambos  
(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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ Means of injury: 0

23. Signature: Henry H. Corn (M. D. or other) \_\_\_\_\_  
Address: St. Mary's Hosp St. Louis Date signed: 10-10-46

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

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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.....

*Oliver E. Fendley*

Licensed Embalmer No. *448*

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.**