No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 13 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19083

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3175

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis - 18
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lutheran Hospital O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days (Specify whether years, months or days)
In this community 10 days.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo - (b) County STU
(c) City or town St. Louis - 10 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4337 a - Lafayette a 9
(If rural, give location)
(e) Citizen of foreign country? No - (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME Peter Joseph Limmer

3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex M.
5. Color or race W.
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May - 8 - 1947 (Month) (Day) (Year)

8. AGE: Years — Months 8 Days 10 If less than one day hr. — min.

9. Birthplace St. Louis - (City, town, or county) Mo. O (State or foreign country)
10. Usual occupation New Born -
11. Industry or business —

FATHER
12. Name Joseph J. Limmer
13. Birthplace Munich (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Aurora Martinez -
15. Birthplace Puerto Rico (City, town, or county) U.S.A. (State or foreign country)

16. (a) Informant Lutheran Hospital
(b) Address 2646 Potomac Str.
17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 5-29-47 (Month) (Day) (Year)
(c) Place: burial or cremation Washington
18. (a) Signature of funeral director W. Ruth
(b) Address Geo. Ruth
19. (a) JUN 2 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18th year 1947 hour 2.55 minute P.M.
21. I hereby certify that I attended the deceased from May 12th 1947 to May 18th 1947 that I last saw him alive on May 18th 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Prematurity (7 mo.)	11 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
✓ Of autopsy Prematurity

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 [illegible] (M. D. or other)
Address 4637 Pingston Ave. Date signed 5-19-47

(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.