

S. No. 2
DM-5-43
v. 5-17-39
P 1 X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 8 1947
Registration District No. **318**

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **25797**
Registrar's No. **7100**

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

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. LOUIS MATERNITY 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)

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

4. Sex **MALE 0** 5. Color or race **WHITE**
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 **JULY 1 47**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 6 hr. 00 min.

9. Birthplace **St. Louis Missouri 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business
12. Name..... **GEORGE FRANCIS LOHMAN**
13. Birthplace..... **AVISTON ILLINOIS**
(City, town, or county) (State or foreign country)
14. Maiden name..... **MONICA MARY HENDELL**
15. Birthplace..... **LONDON ENGLAND 4**
(City, town, or county) (State or foreign country)

16. (a) Informant..... **ST. LOUIS MATERNITY HOSPITAL**
(b) Address..... **630 KINGSHWAY, ST. LOUIS MO.**

17. (a) **Buried** (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... **Anatomical Board**

18. (a) Signature of funeral director..... **W. Richter**
(b) Address..... **JUL 31 1947 00**

19. (a) **JUL 2 1947** (b) **J. F. Gredeck**
(Date received local health authority) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... **MISSOURI** (b) County..... **St. Louis**
(c) City or town..... **ST. LOUIS 17**
(If outside city or town limits, write "RURAL")
(d) Street No. **1147 N. Kingshighway**
12 (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **JULY** day **2**
year **47** hour **7** minute **15** P.M.
21. I hereby certify that I attended the deceased from **June 30**
19 **47**, to **July 2**, 19 **47**
that I last saw him alive on **July 2**, 19 **47**
and that death occurred on the date and hour stated above.
Immediate cause of death..... **massive atelectasis** Duration **30 hr**
Due to..... **Prematurity**
Due to..... **159**
Other conditions.....
(Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy..... **massive atelectasis**
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?
While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature..... **W. D. Lawler M.D.** (Physician or other)
Address..... **4500 Alvin St. St. Louis, Mo.** Date signed **7/5/47**

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.