S. No. 2
M—1/47
v. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 15 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39869

Primary Registration District No. 1003

Registrar's No. 11135

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: 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)
In this community

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. 4440a Clarence
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Adolph Lachmann
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Alvina
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased Nov. (Month) 29 (Day) 1877 (Year)

8. AGE: Years	Months	Days	If less than one day
70	0	5	hr. min.

9. Birthplace Germany (City, town, or county) (State or foreign country)
10. Usual occupation Clerk
11. Industry or business Probate Court
FATHER
12. Name Unknown Lachmann
13. Birthplace Germany (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace Germany (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Alvina Lachmann
(b) Address 4440a Clarence Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Johns Cemetery
18. (a) Signature of funeral director Provost Und. Co.
(b) Address 3710 N. Grand Blvd.
19. (a) DEC 5 1947 (Date received local registrar) (b) J. F. Breneck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 4 year 1947 hour 4 minute 30 A.M.
21. I hereby certify that I attended the deceased from Nov 15, 1947 to Dec 4 1947 that I last saw him alive on Dec 4 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
cerebral	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause of 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 (M. D. or other)
Address Date signed

Jefferson City Printing Co.

(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 Albert Mayfield

Licensed Embalmer No. 3077

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.