

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **21061**  
Registrar's No. **5724**

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Infirmary Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2/5/46 to 6/24/48  
(Specify whether years, months or days)

3: (a) PRINT FULL NAME PHILLIP LAHM

3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

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

7. Birth date of deceased: Nov 21 1864  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>7</u>	<u>3</u>	hr. _____ min. _____

9. Birthplace Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation Baker

11. Industry or business \_\_\_\_\_

12. Name Phillip Lahm

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

14. Maiden name Anna Rhode

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

16. (a) Informant City Infirmary Records

(b) Address 5800 Arsenal St.

17. (a) Burial (b) Date thereof: 6/28/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation N St Marcus Cemetery

18. (a) Signature of funeral director J L Ziegenhein & Sons

(b) Address 7027 Gravois

19. (a) Jun 25 1948 (b) J. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5800 Arsenal St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24  
year 1948 hour 3 minute 00 P.M.

21. I hereby certify that I attended the deceased from May 1, 1948 to June 24, 1948  
that I last saw him alive on June 24, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia, terminal Duration 48 hrs

Due to Uremia - Arteriosclerotic and Hypertensive Cardiovascular Renal Disease Duration 2 weeks

Due to Disease

Other conditions 131 in  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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

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? \_\_\_\_\_

18 While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature Moses Orndorff M.D. M. D. or other \_\_\_\_\_

Address 3903 Olive Date signed 6/25/48

**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

*W G Peterson*

Licensed Embalmer No. *3767*

P. O. Address. *7027 Gravo*

**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.**