

FILED MAY 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14740

#42316

REG. DIST. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 3884

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>0</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>27</u>		d. STREET ADDRESS (If rural, give location) <u>2824 N. 23RD ST</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1.</u>				3. NAME OF DECEASED a. (First) <u>JOSEPH</u> b. (Middle) <u>LERCH</u> c. (Last) <u>LERCH</u>			
4. DATE OF DEATH (Month) (Day) (Year) <u>April 27, 1950</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>DIVORCED 1/2</u>	
8. DATE OF BIRTH <u>Nov-16-1911</u>		9. AGE (in years last birthday) <u>38</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 14 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BROKER</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>August Lerch</u>		13b. MOTHER'S MAIDEN NAME <u>Nellie Hildebrand</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Helen Lerch 2824 N. 23RD ST.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis Far advanced</u>				INTERVAL BETWEEN ONSET AND DEATH? <u>3 mo.</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Syphilis, late - activity undetermined Had adequate Rx.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/20/50</u> to <u>4/27/50</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>4/27/50</u> , 19 <u>50</u> , and that death occurred at <u>5:30pm</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>James A. Hutchinson M.D.</u>				23b. ADDRESS <u>1515 Lafayette Ave.,</u>		23c. DATE SIGNED <u>4/28/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>4/29/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>VAL HALLA</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>APR 28 1950 J. B. Pasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Street & Carroll 400 Nat (Bldg)</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

APR 28 1950

Emb separate Certificate file

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

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.