

FILED MAY 23 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

18403

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1309

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>2049</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Firmin Desloge Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>6906 Bruno Avenue</u> <u>0</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) <u>Joseph</u> c. (Last) <u>Lutz</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>12</u> (Year) <u>1950</u>
5. SEX <u>Male</u> <u>0</u>	6. COLOR OR RACE <u>White</u>
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> <u>2</u>	8. DATE OF BIRTH <u>5-21-68</u>
9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____
IF UNDER 4 HRS. Hours _____ Mins. _____	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nil</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>George Lutz</u>	13b. MOTHER'S MAIDEN NAME <u>Barbara Wagner</u>	14. NAME OF HUSBAND OR WIFE <u>Louisa Brungard</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs E. Huges</u>	ADDRESS <u>4252 West Pine</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Benign hypertrophy of prostate</u> DUE TO (c) <u>Chronic hypertensive cardiovascular disease</u>		
11. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of mouth</u>			

19a. DATE OF OPERATION <u>4-26-50</u>	19b. MAJOR FINDINGS OF OPERATION <u>Bilateral cataract, right eye.</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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>1431</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 March 27 1950, to May 12, 1950, that I last saw the deceased alive on May 12, 1950, and that death occurred at 7:45 P.m., from the causes and on the date stated above.

23a. SIGNATURE Maxwell Rachlin, M.D. (Degree or title) <u>Maxwell Rachlin M.D.</u>	23b. ADDRESS <u>Firmin Desloge Hospital</u> <u>1325 S. Grand, St. Louis, Missouri</u>	23c. DATE SIGNED <u>5-13-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>May 15 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
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DATE REC'D BY LOCAL REG. <u>MAY 14 1950</u>	REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Schnur</u>	ADDRESS <u>3125 Lafayette</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

X

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. 4014

P. O. Address 3125 Lafayette

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.