No. 300
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38723

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9268

19

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

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Alexian Bros. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: 2237
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 0
d. STREET ADDRESS (If rural, give location): 1700a Allen Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Roy
b. (Middle): E.
c. (Last): Lahmann

4. DATE OF DEATH (Month) (Day) (Year): 10/30/50

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single 0
8. DATE OF BIRTH: May 17, 1908
9. AGE (In years last birthday): 42 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beer Bottler
10b. KIND OF BUSINESS OR INDUSTRY: Falstaff Brewery
11. BIRTHPLACE (State or foreign country): St. Louis, Missouri 0
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Ernst Lahmann
13b. MOTHER'S MAIDEN NAME: Minnie Kittel
14. NAME OF HUSBAND OR WIFE: -----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 498-01-5466
17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: Minnie Lahmann--1700a Allen

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): AC Appendicitis — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Peritonitis — 5 days
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 5501

22. *I hereby certify that I attended the deceased from* 10/24, 1950, *to* 10/30, 1950, *that I last saw the deceased alive on* 10/30, 1950, *and that death occurred at* 2:35p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. A. Mollekin 0
23b. ADDRESS: 2608 S. Kingshighway
23c. DATE SIGNED: 11/1/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 0
24b. DATE: 11/2/50
24c. NAME OF CEMETERY OR CREMATORY: N. St. Marcus
24d. LOCATION (City, town, or county) (State): St. Louis Co., Missouri

DATE REC'D BY LOCAL REG.: Nov 1 1950
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Wacker-Helderle 3634 Gravois

(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.....

.....

working under my personal supervision.

Student Embalmer No.....

Signed Robert C Wheeler

Signed.....
Student Embalmer

Licensed Embalmer No. 2128

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.