

FILED JAN 20 1951

STANDARD CERTIFICATE OF DEATH

43748

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. **1003** Registrar's No. **11288**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		a. STATE Missouri b. COUNTY St. Louis Co.	
c. LENGTH OF STAY (in this place) 17 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN University City 4356	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES Hospital		d. STREET ADDRESS (If rural, give location) 7642 Fairham Ave.,	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) CHARLES b. (Middle) MARTIN c. (Last) LEHMAN			12 (Month) 31 (Day) 1950 (Year)		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 2, 1910.	9. AGE (In years last birthday) 40	IF UNDER 1 YEAR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Die sitter		10b. KIND OF BUSINESS OR INDUSTRY Wagner E. Co.		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Fred Lehman		13b. MOTHER'S MAIDEN NAME Minnie Meyeling		14. NAME OF HUSBAND OR WIFE Selma M. Lehman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Selma M. Lehman, 7642 Fairham Ave.,	

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized peritonitis		INTERVAL BETWEEN ONSET AND DEATH 2 d.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Perforated gall bladder DUE TO (c) Cholecystitis, acute		
	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 <input checked="" type="checkbox"/> NO <input 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 586X

22. I hereby certify that I attended the deceased from **Dec. 14, 1950**, to **Dec. 31, 1950**, that I last saw the deceased alive on **Dec. 31, 1950**, and that death occurred at **3:28 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) FR Brade M.D.	23b. ADDRESS Barnes Hospital	23c. DATE SIGNED 12/31/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE Jan. 31 1951	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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DATE REC'D BY LOCAL REG. JAN 2 1951	REGISTRAR'S SIGNATURE J B Lusater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jos. W. Clark 1125 Hodiamont Ave.,
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Me

working under my personal supervision.

Student Embalmer No.....

Signed.....

G. W. Wilkinson

Signed.....

Student Embalmer

Licensed Embalmer No. 35175

P. O. Address St. Louis Mo.

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.