

FILED FEB 9 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2744
Registrar's No. 383

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 383			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay		4870			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthonys				d. STREET ADDRESS (If rural, give location) 706 Lemay Ferry					
3. NAME OF DECEASED (Type or Print) Ernestine Luthenauer			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH Jan. 11 1951		(Month) (Day) (Year)		5. SEX Female		6. COLOR OR RACE White			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Married		8. DATE OF BIRTH Sept. 11 1914		9. AGE (In years last birthday) 36		IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U			
13a. FATHER'S NAME Peter Stahl		13b. MOTHER'S MAIDEN NAME Ernestine Weibert		14. NAME OF HUSBAND OR WIFE Oliver					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Oliver Luthenauer 706 Lemay Ferry					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage - left Antecedent causes: ventricular striated artery, Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) atherosclerosis DUE TO (c) Hypertension II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		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? 331X							
22. I hereby certify that I attended the deceased from 18 July, 1949, to 11 Jan., 1951, that I last saw the deceased alive on 11 Jan., 1951, and that death occurred at 10:30 a.m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) _____				23b. ADDRESS 3804 Wilmington		23c. DATE SIGNED 1-13-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-13-1951		24c. NAME OF CEMETERY OR CREMATORY Mt. Hope		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.			
DATE REC'D BY LOCAL REG. JAN 15 1951		REGISTRAR'S SIGNATURE J. B. Hunter		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jos. P. Fendler Jr. 7128 Michigan					

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

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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.

Signed.....
Student Embalmer

Signed

Student Embalmer No.....

Licensed Embalmer No. 3093

P. O. Address 7128 MacKinnon

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.