

FILED DEC 8- 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39355

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. **1003** Registrar's No. **10625**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>ST. LOUIS, MISSOURI</b> )		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST LOUIS</b>	
c. LENGTH OF STAY (in this place)		2229	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1</b>		d. STREET ADDRESS (If rural, give location) <b>22 2607 CHOUTEAU AVE</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>AMELIA</b>	b. (Middle) <b>ROSE</b>	c. (Last) <b>LUTZ</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 28, 1951</b>
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>7/20/1877</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>8</b>	IF UNDER 2 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>X</b>	11. BIRTHPLACE (State or foreign country) <b>ST LOUIS MO U</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>PETER ROSE</b>	13b. MOTHER'S MAIDEN NAME <b>HENRIETTA SCHWABE</b>	14. NAME OF HUSBAND OR WIFE <b>Jos. P. Lutz Decd</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b></b>	17. INFORMANT'S SIGNATURE OR NAME <b>PHIL ROSE</b>	ADDRESS <b>3666 A Shaw</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>BRONCHOPNEUMONIA</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>MALNUTRITION</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>CHRONIC LEG ULCERS</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>491X</b>
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22. I hereby certify that I attended the deceased from **11-23-51**, 19**51**, to **11-28-51**, 19**51**, that I last saw the deceased alive on **11-28-51**, 19**51**, and that death occurred at **12:25Pm.**, from the causes and on the date stated above.

23. SIGNATURE (Degree or title) <b>Victor B. Kieffer M.D.</b>	23b. ADDRESS <b>1515 Lafayette Avenue</b>	23c. DATE SIGNED <b>11-28-51</b>
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24a. (BURIAL) CREMATION, REMOVAL (Specify) <b>U</b>	24b. DATE <b>12/1/51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>NEW ST MARCUS</b>	24d. LOCATION (City, town, or county) (State) <b>ST LOUIS MO</b>
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DATE REC'D BY LOCAL REG. <b>NOV 29 1951</b>	REGISTRAR'S SIGNATURE <b>Paul Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>AM BROSTER</b>	ADDRESS <b>MORTUARY 6633 CLAYTON</b>
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(Licensed Embalmer's Statement on Reverse Side)

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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student (.....)

Student Embalmer

Signed

*Ernest W. Spillars*

Licensed Embalmer No. *4080*

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.