

FILED JUN 4 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19617
5125
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. LENGTH OF STAY (in this place) 4 WKS	c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		d. STREET ADDRESS (If rural, give location) 3952 Cote Brillante
d. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL					
3. NAME OF DECEASED a. (First) Mabel		b. (Middle)		c. (Last) Lehman	
4. DATE OF DEATH (Month) (Day) (Year) May 19 1953	5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Oct 2, 1891	9. AGE (In years last birthday) 61 7/17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Mo	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Chas P. McClellan		13b. MOTHER'S MAIDEN NAME Elizabeth Grassmuck		14. NAME OF HUSBAND OR WIFE Jacob Lehman	
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 ADDRESS Clarence Lehman, 3952 Cote Brillante		

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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of ovaries ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 6 mo
		2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Spontaneous hypoglycemia			2 mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 175X				

22. I hereby certify that I attended the deceased from April 20, 1953, to May 19, 1953, that I last saw the deceased alive on May 19, 1953, and that death occurred at 9 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. A. Neumann M.D.
23b. ADDRESS 3701 Grand St
23c. DATE SIGNED 5-21-53

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE May 22, 1953
24c. NAME OF CEMETERY OR CREMATORY Memorial Park
24d. LOCATION (City, town, or county) (State) Lucas & Hunt Rd Mo

DATE REC'D BY LOCAL REGISTRY'S SIGNATURE MAY 22 1953 J. Carl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bull-Campbell Mortuary, 4215 Lindell

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed Rex E Campbell
Student Embalmer No.....

Licensed Embalmer No. 3881

P. O. Address W. Harris 8 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.