FILED JUN 24 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22975

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5717

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): 2-WKS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Desloge Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St.Louis
d. STREET ADDRESS (If rural, give location): 2107a Palm Street

2264

3. NAME OF DECEASED (Type or Print): a. (First) Herman b. (Middle) L. c. (Last) Lagershausen

4. DATE OF DEATH (Month) (Day) (Year): 6-8-53

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): M.

8. DATE OF BIRTH: July 24,1898

9. AGE (In years last birthday): 54 — If under 1 year: Months 10, Days 14 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brewery Driver

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country): St.Louis,Mo.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Herman Lagershausen

13b. MOTHER'S MAIDEN NAME: Lena Haas

14. NAME OF HUSBAND OR WIFE: Mrs.Helen Lagershausen

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.: not known

17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: Mrs.Helen Lagershausen,2107a Palm St.

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) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 mo.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Arteriolar nephrosclerosis — 1-2 yrs

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?: 446X

22. *I hereby certify that I attended the deceased from* 5-23, 1953, *to* 6-8, 1953, *that I last saw the deceased alive on* 6-7, 1953, *and that death occurred at* 12 01 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm. H. Schiermann M.D.

23b. ADDRESS: Jerum Desloge Hosp.

23c. DATE SIGNED: 6-8-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: June 11,1953

24c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

24d. LOCATION (City, town, or county) (State): St.Louis,Mo.

DATE REC'D BY LOCAL REG.: JUN 9 1953

REGISTRAR'S SIGNATURE: J. Earl Smith

25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Arthur J. Donnelly 3840 Lindell Blvd.

(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~~ [illegible]

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

working under my personal supervision.

Student .....
Student Embalmer

Signed [illegible]

Licensed Embalmer No. 4699

P. O. Address [illegible]

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

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