

15. No. 300
10. 48

FILED JUN 26 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23489**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **1708**

1000
4

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY _____	
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 3 Monis.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Ferry Halls Memorial Home		e. STREET ADDRESS (If rural, give location) 1951 Warren St	
3. NAME OF DECEASED (Type or Print) Anton Lodes		4. DATE OF DEATH (Month) (Day) (Year) 6 19 53	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-29-1877
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman (retired)	9b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (City and State or Foreign Country) Ill	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John Lodes	
13b. MOTHER'S MAIDEN NAME Barbara Hartman		14. NAME OF HUSBAND OR WIFE Minnie Lodes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No.		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT'S SIGNATURE OR NAME Mrs Minnie Lodes		ADDRESS 1951 Warren 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease (aortic regurgitation) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Right hemiplegia, Senile dementia	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4200	
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? _____		22. I hereby certify that I attended the deceased from March 25, 1953 , to June 19, 1953 , that I last saw the deceased alive on June 16, 1953 , and that death occurred at 11:00 p.m. , from the causes and on the date stated above.	
23a. SIGNATURE Levey Littmann MD (Degree or title) _____		23b. ADDRESS 8231 Clayton Rd (17)	
23c. DATE SIGNED 6/20/53		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 6-22-53		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery St. Louis, Mo	
24d. LOCATION (City, town, or county) (State) _____		25. FUNERAL DIRECTOR'S SIGNATURE Goodhart-Goodhart ADDRESS 2228 St. Louis, Ave	
DATE REC'D BY LOCAL REG. 6-20-53		REGISTRAR'S SIGNATURE Herbert R. Dombi MD	

P.T. (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 Student Embalmer No.

working under my personal supervision..

Student
Signature of Student Embalmer

Signed..... *John S. Penner*

Licensed Embalmer No. *4194*

P. O. Address *St. Louis*

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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