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FILED JUL 28 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26021

BIRTH NO. _____ REG. DIST. NO. 305 PRIMARY REG. DIST. NO. 6047 Registrar's No. 22

1. PLACE OF DEATH
a. COUNTY St Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wentzville Mo
c. LENGTH OF STAY (in this place) 3 yr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY St Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wentzville Rural
d. STREET ADDRESS (If rural, give location) 0920 0

3. NAME OF DECEASED (Type or Print) a. (First) Herman b. (Middle) William c. (Last) Lammers

4. DATE OF DEATH (Month) July (Day) 1 (Year) 1953

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Dec 13 1871
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR: Months 6 Days 18 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookeeping
10b. KIND OF BUSINESS OR INDUSTRY Bookeeper
11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Herman Lammers
13b. MOTHER'S MAIDEN NAME Wilhelmena Peters
14. NAME OF HUSBAND OR WIFE Emma Lammers

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. 488-18-1696A
17. INFORMANT'S SIGNATURE OR NAME Forest Lammers ADDRESS Wentzville Mo

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) Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 Day

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Cerebral Hemorrhage — 3 Days
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 331X
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?

22. *I hereby certify that I attended the deceased from* June 28 1953, *to* July 1, 1953, *that I last saw the deceased alive on* July 1, 1953, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Claude W Grace M.D. (Degree or title)
23b. ADDRESS Wentzville Mo
23c. DATE SIGNED 7-3-53

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-4-53
24c. NAME OF CEMETERY OR CREMATORY Linn Cemetery
24d. LOCATION (City, town, or county) Wentzville (State) Mo

DATE REC'D BY LOCAL REG. July 10 1953
REGISTRAR'S SIGNATURE Martin [illegible] 408
25. FUNERAL DIRECTOR'S SIGNATURE T. E. Pitman Funeral Home ADDRESS Wentzville Mo

(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 Annetta M. Pitman

Licensed Embalmer No. 3055

P. O. Address Wentzville M

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

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