

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35000

State File No.

FILED OCT 18 1954

BIRTH NO.		REG. DIST. NO. <u>310</u>		PRIMARY REG. DIST. NO. <u>3058</u>		Registrar's No. <u>210</u>	
1. PLACE OF DEATH a. COUNTY <u>Saint Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Saint Charles</u>		c. LENGTH OF STAY (In this place) <u>D.O.A.</u>		c. CITY OR TOWN <u>Saint Charles</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Saint Joseph Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>1125 Hall St.</u> 09230			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fritz</u>		b. (Middle) <u>J.</u>		c. (Last) <u>Luetkenhaus</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 13, 1954</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Aug. 5, 1889</u>	
9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>8</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Saint Paul, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Luetkenhaus</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Dove</u>		14. NAME OF HUSBAND OR WIFE <u>Barbara Burkemper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) <u>Yes W.W. # 1</u>		16. SOCIAL SECURITY NO. <u>488-26-0372</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. F. Luetkenhaus, St. Charles, Mo.</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral vascular hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>art. sclerotic cardio-vascular disease with hyperleucemia</u> DUE TO (c) <u></u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>several years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>443X</u>				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) m.		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 <u>6-1-1954</u> , to <u>10-13-1954</u> , that I last saw the deceased alive on <u>10-7-1954</u> , and that death occurred at <u>8:00 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Name or title) <u>Wayne O. Gorka M.D.</u>				23b. ADDRESS <u>2739 N. Grand St. Louis, Mo.</u>		23c. DATE SIGNED <u>10-15-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 16, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Saint Charles, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>6 Oct 16 1954</u>		REGISTRAR'S SIGNATURE <u>Frankie Hamilton</u> <u>284-0</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.C. Dallenmeyer St. Charles, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

3

OCT 25

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 *Frank R. Analer*.....

Licensed Embalmer No. *48*.....

P. O. Address *St. Charles*.....

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**