

health, Welfare public service
 000 -56
 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 23a. BURIAL, CREMATION, REMOVAL (Specify)
 23b. DATE
 23c. NAME OF CEMETERY OR CREMATORY
 23d. LOCATION (City, town, or county) (State)
 24. FUNERAL DIRECTOR ADDRESS
 25. DATE RECD. BY LOCAL REG.
 26. REGISTRAR'S SIGNATURE
 (Licensed Embalmer's Statement on Reverse Side)

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED SEP 4 1957

29692

STATE FILE NUMBER

Registration District No. **318** Primary Registration District **1003**

Registrar's No. **7652**

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, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 ST. LOUIS CITY HOSP.			Length of stay in lb #1	STREET ADDRESS 298 4107 DAVIS ST			(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First OTTO Middle Last LEMAN				4. DATE OF DEATH Month AUG. Day 13, Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH APRIL 2 1881		9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CARL LEMAN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address PATRICIA CONDON 4107 DAVIS ST.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Sq cell carcinoma of palate, tonsils and tongue. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Tuberculosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 8/3/57 to 8/13/57 and last saw her alive on 8/13/57 Death occurred at 8:20 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) David S. Johnson, M.D.				22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 8/14/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE AUG. 16 1957		23c. NAME OF CEMETERY OR CREMATORY MISSOURI CREMATORY		23d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
24. FUNERAL DIRECTOR ADDRESS Thomas Ketter 2906 Gravois		25. DATE RECD. BY LOCAL REG. AUG 15 57		26. REGISTRAR'S SIGNATURE Carl Smith MD			

(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 em

by me, or by Student Embalmer No.

working under my personal supervision..

Student

Signature of Student Embalmer

Signed

James C. Hill

Licensed Embalmer No. 43

P. O. Address 2906

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.