

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027163

STATE FILE NUMBER

REG AUG 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7354

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION # 1. ST. LOUIS CITY HOSP.		Length of stay in 1b # 1. 2/09	d. STREET ADDRESS (If outside, give location) 4256 PRAIRIE
3. NAME OF DECEASED (Type or print) First MIDDLE LAST CLIFFORD LEMEN		4. DATE OF DEATH Month JULY Day 28 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUG 15 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 50
11. BIRTHPLACE (City and state or country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U-S-A	
13a. FATHER'S NAME CLARENCE A LEMEN		13b. MOTHER'S MAIDEN NAME ELLEN C BARLOW	
14. NAME OF HUSBAND OR WIFE		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. 496-18-8015		17. INFORMANT JAMES LEMEN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Laennec's Cirrhosis of liver</i>		INTERVAL BETWEEN ONSET AND DEATH <i>unk.</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		581.1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Hepatic Coma</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <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 7/1/58 to 7/26/58 and last saw her alive on 7/26/58 Death occurred at 1:35 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.		22. ADDRESS 1515 LAFAYETTE AVE.	
21a. SIGNATURE <i>John A. Chapman MD</i>		22b. ADDRESS 1515 LAFAYETTE AVE.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY 26 1958	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEM
23d. LOCATION (City, town, or county) ST. LOUIS MO		23e. (State)	
24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravoia		25. DATE RECD. BY LOCAL REG. JUL 28 '58	
26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Leo J. Budd*

Licensed Embalmer No. *3989*

P. O. Address *St. Louis*

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.