

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030705

STATE FILE NUMBER

FILED SEP 15 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8389

300
-57

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>AFFTON 4810</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. BAPTIST HOSPITAL</u>				Length of stay in lb		d. STREET ADDRESS <u>7920 JOEL</u>		
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>M.</u> Last <u>LUECKE</u>				4. DATE OF DEATH <u>AUG. 27 1958</u> Month <u>Aug.</u> Day <u>27</u> Year <u>1958</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 8 1894</u>		
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIDOW</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>		11. BIRTHPLACE (City and state or country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>LOUIS RICHERT</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>WILLIAM L. LUECKE</u> (DEC'D)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WILLIAM LUECKE, JR.</u> Address <u>AFFTON, Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.		DUE TO (b) <u>arteriosclerotic heart disease</u>						
		DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.0</u>							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 _____ a.m. _____ p.m. _____								
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>6-18-46</u> to <u>8-22-58</u> and last saw her alive on <u>8-22-58</u> Death occurred at <u>10:35 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>W. H. Martin M.D.</u> (Degree or title)				22b. ADDRESS <u>3507 Polonas</u>			22c. DATE SIGNED <u>8-29-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>AUG. 30 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM</u>			23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Co Mo</u>		
24. FUNERAL DIRECTOR <u>Thomas Bates 2906 Gravis</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>AUG 30 '58</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u> S.P.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

PR 1-1863

12-2 } Friday
5-7 }

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 Leaf 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.