

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008494  
STATE FILE NUMBER

FILED MAR 30 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 314

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-57

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1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b> <span style="float: right;">1170</span>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hosp. D.O.A</b>		Length of stay in lb <b>16 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>619 Paris Ave.,</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First	Middle	Last	Month	Day	Year	
<b>DONALD</b>	<b>THOMAS</b>	<b>LEHR</b>	<b>March</b>	<b>23</b>	<b>1959</b>	

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 8, 1903</b>	9. AGE (In years last birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Const. Foreman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Lawton Con'st Co.</b>	11. BIRTHPLACE (City and state or country) <b>Waterloo, Iowa</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Mr. Charles Lehr</b>	13b. MOTHER'S MAIDEN NAME <b>Lessie Strong</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs. Vera B. Lehr</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>500-07-9705</b>	17. INFORMANT <b>Mrs. Vera B. Lehr, St. Joseph, Mo.</b>	Address <b>619 Paris Ave.,</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arteriosclerotic heart disease</b>	
	DUE TO (c) <b>4200</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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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
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21. Attended the deceased from <b>4-26-57</b> to <b>3-23-59</b> and last saw him alive on <b>12-22-58</b> Death occurred at <b>10:15 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Richard L. Maginn M.D.</b>	22b. ADDRESS <b>Physician 216, St. Joseph Mo</b>	22c. DATE SIGNED <b>3-24-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-28-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>
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24. FUNERAL DIRECTOR <b>Stacey Funeral Home</b>	ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Mar. 27, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mr. Clark Standell</b>
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(GAS)

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.  
Dr. Richard L. Maginn  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

APR 7 1959

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 Charles E. Bennett

Licensed Embalmer No. 41677

P. O. Address St. Joseph Mo.

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.