Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008815
STATE FILE NUMBER

FILED APR 14 1959

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 111

1. PLACE OF DEATH
a. COUNTY COLE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON CITY, MO. Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 100A Clay Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY COLE
c. CITY OR TOWN JEFFERSON CITY 0264 Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 100A Clay Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First AUGUST Middle FRANK Last LUETKEWITTE

4. DATE OF DEATH Month APRIL Day 7 Year 1959

5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]

8. DATE OF BIRTH MARCH 13, 1891

9. AGE (In years last birthday) 68 IF UNDER 1 YEAR: Months 0 Days 24 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PRESSMAN 10b. KIND OF BUSINESS OR INDUSTRY MID STATE

11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME FRANK HENRY LUETKEWITTE 13b. MOTHER'S MAIDEN NAME ELIZABETH GLASER

14. NAME OF HUSBAND OR WIFE MATILDA DEBROECK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) WAR I

16. SOCIAL SECURITY NO. 490-09-4189

17. INFORMANT JAMES LUETKEWITTE Address J C MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Haemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Instant
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Cardio Vascular Disease — 5 yrs
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 Nov 1955, to Apr. 7, 1959 and last saw her/him alive on Mar. 18, 1959
Death occurred at 12:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE L. B. Klebba (Degree or title) M.D.
22b. ADDRESS Jefferson City, Mo.
22c. DATE SIGNED 4-12-59.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 4/9/59
23c. NAME OF CEMETERY OR CREMATORY RESURRECTION
23d. LOCATION (City, town, or county) (State) JEFFERSON CITY, MO.

24. FUNERAL DIRECTOR Sylvester Dulle ADDRESS J C MO.
25. DATE RECD. BY LOCAL REG. 11 April 1959
26. REGISTRAR'S SIGNATURE R. P. Norris, MD-MR

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

APR 21 1959

US 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 Sylvester Quille

Licensed Embalmer No. 4321

P. O. Address Jefferson

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.