

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014532
State File No.

FILED APR 27 1959

BIRTH MO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 104

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		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, write RURAL and give township) <u>St. Charles</u>		c. CITY OR TOWN <u>Overland</u> <u>4008</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>8911 Argyle</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Anna</u>	b. (Middle)	c. (Last) <u>Lueck</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 17, 1959</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 29, 1881</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>5</u> Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Macklenberg, Germany</u> <u>4</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Fredrick Lueck</u>	13b. MOTHER'S MAIDEN NAME <u>Louise Hartmack</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Lueck</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>492-36-2962</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Harold Lueck, Overland, Mo.</u>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>		Unknown
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>332 X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 7/28, 1958, to 4/17, 1959, that I last saw the deceased alive on 4/17, 1959, and that death occurred at 4:05 P.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Gene W. Potter M.D.</u>	(Degree or title)	23b. ADDRESS <u>114 N. Main St. St. Charles, Mo.</u>	23c. DATE SIGNED <u>4/20/59</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>April 20, 1959</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Lutheran Com.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Charles, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>APR 20-59</u>	REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur C. Baue, St. Charles, Mo.</u>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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MAY 18 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 *David C. Bane*.....

Licensed Embalmer No. *506*.....

P. O. Address *St. Charles*.....

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.