

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015344

STATE FILE NUMBER  
2 3459  
REGISTRATION DISTRICT NO.

FILED APR 24 1959

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (IF NOT in hospital, give location) 6 HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>4341 Westminster</b>	
Length of stay in 1b <b>4 days</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Emma Lutz</b>			4. DATE OF DEATH Month Day Year <b>4-6-59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1872</b>	9. AGE (In years last birthday) <b>86</b>	IF UNDER 1 YEAR Months Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never Worked</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Mo. St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
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13a. FATHER'S NAME <b>Fred erick Linders</b>		13b. MOTHER'S MAIDEN NAME <b>Charlotte Koenegan</b>		14. NAME OF HUSBAND OR WIFE <b>-Henry (Dec'd)</b>	
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>None</b>		17. INFORMANT <b>Mrs. Charlotte Springs, 7049 Lindenwood, St. L.</b>	

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>Anterior Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		<b>4 days</b>		
	DUE TO (c) <b>Generalized Arteriosclerosis</b>		<b>4 days</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. I attended the deceased from <b>4-2-59</b> , to <b>4-6-59</b> and last saw her/him alive on <b>4-6-59</b> Death occurred at <b>6:30 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>		22b. ADDRESS <b>5800 Arsenal</b>		22c. DATE SIGNED <b>4/6/59</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>4/8/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Roman Catholic Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Lucas Hunt Co. St. Louis County, Mo.</b>	
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24. FUNERAL DIRECTOR <b>Louis H. Popp, Inc. Kirkwood Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>APR 8 '59</b>		26. REGISTRAR'S SIGNATURE <b>Walter Smith, M.D.</b>	
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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 *Framia J. Kelland* .....  
Licensed Embalmer No. *1512* .....  
P. O. Address *Aurora* .....

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.