

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026869

FILED VS AUG 5 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **6961** STATE FILE NUMBER

INDEXED

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|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 6 Years | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Little Sisters of Poor | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS 3400 S. Grand Ave. (If outside, give location) Formerly - 2903 Salena St. | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Pauline Lammlein | | | | 4. DATE OF DEATH Month July Day 26 Year 1959 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 14, 1875 | 9. AGE (last birthday) 84 | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (City and state or country) St. Louis | | 12. CITIZEN OF WHAT COUNTRY U. S. A. |
| 13a. FATHER'S NAME John Doetsch | | | 13b. MOTHER'S MAIDEN NAME Gertrude ? | | 14. NAME OF HUSBAND OR WIFE William Lammlein | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Sr. Marie Jean, Supr., 3400 S. Grand Av. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. CAUSE WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Dis. DUE TO (b) Sen. Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH yes yes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0 | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 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.) | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year _____ | | | | | | |
| 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 St. Louis, Mo | | COUNTY | STATE |
| 21. I attended the deceased from 1/1/59 to 7/26/59 and last saw her alive on 7/27/59 . Death occurred at 2:00 P. M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE R. Megera M.D. (Degree or title) | | | 22b. ADDRESS 8059 Watson Rd. | | | 22c. DATE SIGNED 7/27/59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 7/28/59 | 23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul | | 23d. LOCATION (City, town, or county) St. Louis, Mo. | | (State) | |
| 24. FUNERAL DIRECTOR Gebken Sons ADDRESS 2630 Gravois Ave. | | | 25. DATE RECD. BY LOCAL REG. JUL 27 '59 | 26. REGISTRAR'S SIGNATURE Roald Smith, M.D. | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert T. Lubken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois A

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.