URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 16 1959

59-042124
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 9755

ENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Firmin Desloge Hospital
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St.Louis
c. CITY OR TOWN: Overland
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 9432 Muriel
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Arthur Middle: W. H. Last: Lammers
4. DATE OF DEATH: Month: October Day: 21, Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]
8. DATE OF BIRTH: 8/21/1885
9. AGE (last birthday): 74
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Pevely Dairy Co.
11. BIRTHPLACE (City and state or country): St.Louis,Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: Henry Lammers
13b. MOTHER'S MAIDEN NAME: Anna Sanker
14. NAME OF HUSBAND OR WIFE: Sarah
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 489-05-3177
17. INFORMANT: Della Turner, Address: 5402 Page Ave.

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): Portal vein thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 583X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Myocardial Infarct.
PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]
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 10-19-59, to 10-21-59 and last saw her/him alive on 10-21-59
Death occurred at 6:05 am m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Gilbert N. Lassar M.D.
22b. ADDRESS: 6223 Natural Bridge
22c. DATE SIGNED: 10-23-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 10-24-59
23c. NAME OF CEMETERY OR CREMATORY: Bethlehem Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis Co., Mo.

24. FUNERAL DIRECTOR ADDRESS: Albert H.Hoppe,Inc.,4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: OCT 24 1959
26. REGISTRAR'S SIGNATURE: Floyd Smith, M.D. (H.T.)

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed G W Wilkinson

Licensed Embalmer No. 357

P. O. Address M Lou

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