

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 4 1960

-60-028557

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7285** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 2days	c. CITY OR TOWN Collinsville Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 418 S. Jefferson Ave. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARTHA Middle MARIA Last LEHMANN			4. DATE OF DEATH Month JULY Day 19 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-23-1894	9. AGE (last birthday) 65	IF UNDER 1 YEAR 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 at home	11. BIRTHPLACE (City and state or country) Lithuania	12. CITIZEN OF WHAT COUNTRY Germany	
13a. FATHER'S NAME George Stradas		13b. MOTHER'S MAIDEN NAME Augusta Povalites		14. NAME OF HUSBAND OR WIFE Wilhelm Lehmann	
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. ?	17. INFORMANT Address Wilhelm Lehmann Collinsville, Ill.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MESENTERIC THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH 24 HOURS
DUE TO (b) ARTERIOSCLEROSIS		YEARS
DUE TO (c) 450.0H		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) STATUS POST-OPERATIVE ABDOMINAL PERINEAL RESECTION FOR CARCINOMA OF RECTOSIGMOID		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 Month, Day, Year s.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

21. I attended the deceased from **JULY 13, 1960** to **JULY 19, 1960** and last saw her/him alive on **JULY 19, 1960**
Death occurred at **11:05 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) G. C. Verrill, M.D.	22b. ADDRESS M. D. BARNES HOSPITAL	22c. DATE SIGNED 7/20/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-23-60	23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery
23d. LOCATION (City, town, or county) (State) Collinsville, Illinois		

24. FUNERAL DIRECTOR Herr Funeral Home	ADDRESS Collinsville, Ill.	25. DATE RECD. BY LOCAL REG. JUL 21 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
--	--------------------------------------	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 28 1962

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 *James H. [Signature]*

Licensed Embalmer No. 3577

P. O. Address Collinsville

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.