

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	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 De Paul Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2849 A Keokuk	
3. NAME OF DECEASED (Type or print) First Middle Last MATHIAS LEHN			4. DATE OF DEATH Month Day Year 10-2-1960		
5. SEX Male	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 2-9-1883	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber		11. BIRTHPLACE (City and state or country) Hungary	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Michael Lehn		13b. MOTHER'S MAIDEN NAME Barbara Salm	
14. NAME OF HUSBAND OR WIFE Caroline Keisten		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. 499-30-8916D	
17. INFORMANT Caroline Lehn		Address 2849A Keokuk			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Generalized Atherosclerosis	
		DUE TO (c) 331XH	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) Chronic condition of blood		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	
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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.) Cardiovascular	
20c. TIME OF INJURY Hour a.m. p.m. 10:30 a.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 **August 1955** to **Oct 1960** and last saw him alive on **Oct 20 1960**.
 Death occurred at **St. Louis** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John B. Weep (Degree or title)	22b. ADDRESS 637 N Grand Blvd	22c. DATE SIGNED 10-3-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-5-1960	23c. NAME OF CEMETERY OR CREMATORY SunSet Burial Prk
23d. LOCATION (City, town, or county) St. Louis Co MO.		(State)

24. FUNERAL DIRECTOR WINGBERMUEHLE ADDRESS	25. DATE RECD. BY LOCAL REG. OCT 3 1960	26. REGISTRAR'S SIGNATURE Loal Smith, M.D.
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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 Greg J. [Signature]

Licensed Embalmer No. 4611

P. O. Address Honolulu

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.