

AMENDED **FILED** Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4196** STATE FILE NUMBER

DATE AMENDED

INSTEAD OF DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

J. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (If outside corporate limits, give TOWNSHIP only) **ST. Louis** Length of stay in 1b _____
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Glennon Memorial Hosp** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **Mo** b. COUNTY **ST. LOUIS**
 c. CITY OR TOWN **University City** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **614 Geoffrey Lane** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **Michael** Middle **Lembeck** Last **Lembeck** 4. DATE OF DEATH Month **5** - Day **1** - Year **61**

5. SEX **Male** **6. COLOR OR RACE** **White** **7. Married** **Never Married** **Widowed** **Divorced** **8. DATE OF BIRTH** **1-15-61** **9. AGE** (last birthday) IF UNDER 1 YEAR Months **3** Days **16** IF UNDER 24 HR Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None** **10b. KIND OF BUSINESS OR INDUSTRY** _____ **11. BIRTHPLACE** (City and state or country) **ST. LOUIS MO** **12. CITIZEN OF WHAT COUNTRY** **USA.**

13a. FATHER'S NAME **Henry Lembeck** **13b. MOTHER'S MAIDEN NAME** **Gail Scholle** **14. NAME OF HUSBAND OR WIFE** _____

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.** **None** **17. INFORMANT** **Henry Lembeck** Address **614 Geoffrey Lane**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Patent ductus arteriosus -**
 DUE TO (b) **Anomalous ret-pulmonary artery from aorta.**
 DUE TO (c) **Congenital cyanotic heart disease**
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **754.5**
 PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES 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 **4/30/60** to **5/1/61** and last saw him **5/1/61** ^{when} alive on _____
 Death occurred at **8:02 p.m.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **C. Reelie Haulon M.D.** **22b. ADDRESS** **1325 S-GRAND BLVD St Louis 4.** **22c. DATE SIGNED** **5/2/61.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** **23b. DATE** **5-3-61** **23c. NAME OF CEMETERY OR CREMATORY** **Calvary** **23d. LOCATION** (City, town, or county) **ST. LOUIS MO** (State) _____

24. FUNERAL DIRECTOR **A. Krou** ADDRESS **2707 N Grand** **25. DATE RECD. BY LOCAL REG.** **MAY 3 1961** **26. REGISTRAR'S SIGNATURE** **Loan Smith, M.D.**

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 *Alphonse Tundo*
Licensed Embalmer No. _____

P. O. Address _____

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.