

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-019212
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4860

AMENDED FILED JUN 2 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>Over 25 yrs</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis State</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5400 Arsenal St.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle Last <u>Lehnbeuter</u>	4. DATE OF DEATH Month <u>May</u> Day <u>22nd</u> Year <u>1961</u>
----------------------------------------------------------------------------------------	-----------------------------------------------------------------------

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/30/72</u>	9. AGE (last birthday) <u>88 yrs.</u>	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) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (City and state or country) <u>Highland, Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
-----------------------------------------------------------------------------------------------------------------	---------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME <u>Sebastian Marti</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Cnuer</u>	14. NAME OF HUSBAND OR WIFE <u>Joseph Lehnbeuter</u>
----------------------------------------------	------------------------------------------------	---------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Jos. Lehnbeuter - 4408a Arsenal St.</u>
-----------------------------------------------------------------------------------------------------------------------	----------------------------------------	-------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>420DH</u>	INTERVAL BETWEEN ONSET AND DEATH
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma of left breast</u>	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 <u> </u> 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 COUNTY STATE
-------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	----------------------------------------------

21. I attended the deceased from <u>August 19, 1935</u> to <u>May 22, 1961</u> and last saw her alive on <u>May 22, 1961</u> Death occurred at <u>5:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>R. Helderle M.D.</u> (Degree or title)	22b. ADDRESS <u>5400 Arsenal St.</u>	22c. DATE SIGNED <u>5/22/61</u>
-------------------------------------------------------------	-----------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 25, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Matthew's Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
------------------------------------------------------------	----------------------------------	---------------------------------------------------------------------	-----------------------------------------------------------------------------

24. FUNERAL DIRECTOR <u>WACKER-HELDERLE-3634 Gravois Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 23 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith M.D.</u>
------------------------------------------------------------------	----------------------------------------------------	-----------------------------------------------------

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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

Lawrence M. Bullock

Licensed Embalmer No. 4375

St. Louis, 23, Mo.
City 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.