

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-020691

318

1003

4989

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4989

FILED MAY 23 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1

2 203

3

4 0

5 2

6

7 0

8 2

9

10

11

12 90-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | | | | | | | | | | | |
|--|--|---|---|--|---|--|---|--|---|--|-------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b Lifetime | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | 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 6237 Wilson Ave. | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 6237 Wilson Ave. | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Aloysius Middle Gregory Last Luensmann | | | 4. DATE OF DEATH Month May Day 15 Year 1962 | | 5. SEX Male | | 6. COLOR OR RACE White | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 5/25/94 | 9. AGE (last birthday) 67 | IF UNDER 1 YEAR Months 11 Days 20 | IF UNDER 24 HR Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) driver | | | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (City and state or country) St. Louis Mo. | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | | | | |
| 13a. FATHER'S NAME Theodore Luensmann | | | | 13b. MOTHER'S MAIDEN NAME Henria Bruns | | | 14. NAME OF HUSBAND OR WIFE Anna Longheinrich | | | | | | |
| 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. [REDACTED] | | 17. INFORMANT Alfred Luensmann 6237 Wilson Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myo card. fr DUE TO (b) _____ DUE TO (c) 422.2 | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 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 1st May 25 5:45 to 5-15-62 to P. and last saw him alive on 5-8-62 Death occurred at 1:45 P. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE John D. Smith M.D. | | | | | 22b. ADDRESS 3737 Gravois Ave. | | | 22c. DATE SIGNED 5/15/62 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 5/18/62 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | 23d. LOCATION (City, town, or county) St. Louis County, Mo. | | | (State) | | | | | |
| 24. FUNERAL DIRECTOR Gebken Sons | | | | ADDRESS 2630 Gravois | | 25. DATE RECD. BY LOCAL REG. MAY 16 1962 | | 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 Yau M. Siganos
 Licensed Embalmer No. 4343
 P. O. Address St Louis Mo.

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.