

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036437

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8976**

STATE FILE NUMBER

**FILED SEP 24 1962**

VS 300  
Rev. 4/59

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DATE AMENDED  
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99  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
59  
SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>308 Laurel</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>H. Carl Lutz</b>		4. DATE OF DEATH Month Day Year <b>Sept. 17, 1962</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1908</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trust officer at St. Louis Union Trust Co.</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Henry C. Lutz</b>		13b. MOTHER'S MAIDEN NAME <b>Emma Schoeferling</b>	14. NAME OF HUSBAND OR WIFE <b>Margaret D. Lutz</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes W.W.I.I</b>		16. SOCIAL SECURITY NO. <b>yes</b>	17. INFORMANT <b>St. Louis 12, Missouri. Mrs. Margaret D. Lutz - 308 Laurel Ave.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Posterior myocardial infarct</b> DUE TO (b) <b>Coronary artery disease</b> DUE TO (c) <b>420.1</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs,</b> <b>?</b>
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 <b>5-16-62</b> to <b>9-17-62</b> and last saw him alive on <b>9-17-62</b> Death occurred at <b>10:50 Am</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Chas. J. Smith</b>		22b. ADDRESS <b>6000 W. Floussant</b>	22c. DATE SIGNED <b>9-17-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9-20-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Missouri.</b>
24. FUNERAL DIRECTOR <b>Cupton Chapel Inc. 7233 Delmar Bly'd.</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 17 1962</b>	26. REGISTRAR'S SIGNATURE <b>Wood Smith, M.D.</b>

USE BLACK INK OR TYPEWRITER RIBBON

City  
St. Charles, Mo.  
6000 W. Florissant  
Co 17265

OCT 5 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 Carenice A. Murray

Licensed Embalmer No. 4011

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.