

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044525

STATE FILE NUMBER

318

1003

10841

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED NOV 19 1962

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|---------------------------|------------------------------------------|--|--|--|--|
| DO NOT WRITE ON THIS STUB | AMENDED | | | | |
| VS 300 Rev. 4/59 | DATE AMENDED | | | | |
| 1 | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | | | | |
| 2 | INSTEAD OF | | | | |
| 3 | DOCUMENT | | | | |
| 4 | MEDICAL CERTIFICATION | | | | |
| 5 | SHOULD READ | | | | |
| 6 | BY AFFIDAVIT OF | | | | |
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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 4 Wks. | 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 Deaconess Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 5200 S. Broadway Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Hugo A. Lehmborg | | | 4. DATE OF DEATH Month Day Year Nov. 8 1962 |
| 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 2-21-76 |
| 9. AGE (last birthday) 86 | | 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) Dentist (ret.) | | 10b. KIND OF BUSINESS OR INDUSTRY Dentist | 11. BIRTHPLACE (City and state or country) Holstein, Mo. |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME Louis Lehmborg | |
| 13b. MOTHER'S MAIDEN NAME Marie Muench | | 14. NAME OF HUSBAND OR WIFE Emma Lehmborg | |
| 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. None | 17. INFORMANT Gustav Lehmborg, 7033 Etzel Ave. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia | | | INTERVAL BETWEEN ONSET AND DEATH 1 wk |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 491x | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Ulcerative gastritis; ch. pyelonephritis | | | 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 checked="" type="checkbox"/> NO <input 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 10/05/62 to 11/8/62 and last saw him alive on 11/8/62 Death occurred at 10:45 P on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE W.T. Steen (Degree or title) | | 22b. ADDRESS 5203 Chippewa | 22c. DATE SIGNED 11/12/62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE 11-13-62 | 23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis Mo. |
| 24. FUNERAL DIRECTOR Drehmann-Harral, 1905 Union Blvd. | | 25. DATE RECD. BY LOCAL REG. Nov. 13, 1962 | 26. REGISTRAR'S SIGNATURE Roan Smith, M.D. |

USE BLACK INK OR TYPEWRITER RIBBON

58

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

Dr. W. F. Neun
5203 Chippewa
Hrs. after 2 PM Mon.

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

Albert R. Thompson

Licensed Embalmer No. 4237

P. O. Address H. J. Davis

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.