

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-002299

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 3

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

<p>FILED JAN 21 1963</p> <p>1. PLACE OF DEATH a. COUNTY <u>Lafayette</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u> Length of stay in lb <u>Life</u></p> <p>c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u></p> <p>c. CITY OR TOWN <u>Lexington (Rural)</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>Rural Route #2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>					
<p>3. NAME OF DECEASED (Type or print) First <u>AUGUST W</u> Middle <u>W</u> Last <u>LUEHRMAN</u></p>			<p>4. DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>1963</u></p>				
<p>5. SEX <u>Male</u></p>	<p>6. COLOR OR RACE <u>White</u></p>	<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>December 26 1887</u></p>	<p>9. AGE (last birthday) <u>75</u></p>	<p>IF UNDER 1 YEAR Months Days Hours Min.</p>	<p>IF UNDER 24 HR</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u></p>		<p>11. BIRTHPLACE (City and state or country) <u>Lexington, Mo.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>	
<p>13a. FATHER'S NAME <u>E.J.F. Luehrman</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>Katherine Kraemer</u></p>		<p>14. NAME OF HUSBAND OR WIFE <u>Sophie Graupner</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>60</u></p>		<p>17. INFORMANT Address <u>Mrs. August Luehrman Lexington Missouri</u></p>			
<p>18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY)</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Peritonitis acute</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p style="text-align: center;">DUE TO (b) <u>Ruptured duodenal stump</u> <u>7 days</u></p> <p style="text-align: center;">DUE TO (c) <u>Gastrectomy for duodenal ulcer</u> <u>7 days</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p>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</p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>			
<p>20c. TIME OF INJURY Hour <u>10:15</u> a.m. <u>10:15</u> p.m.</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from <u>12-19-62</u> to <u>1-5-63</u> and last saw him alive on <u>1-5-63</u> Death occurred at <u>10:15</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.</p>							
<p>22a. SIGNATURE <u>J.S. Cope</u> (Degree or title) <u>M.D.</u></p>			<p>22b. ADDRESS <u>Lexington, Missouri</u></p>		<p>22c. DATE SIGNED <u>1, 8, 63</u> (State)</p>		
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE <u>1-7-63</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u></p>		<p>23d. LOCATION (City, town, or county) <u>Lexington, Missouri</u></p>	
<p>24. FUNERAL DIRECTOR ADDRESS <u>Vaughn-Walker Lexington, Mo.</u></p>			<p>25. DATE RECD. BY LOCAL REG. <u>1-7-63</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>Wm. E. Speltz</u></p>		

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 Harold L. Walker

Licensed Embalmer No. 4588

P. O. Address Lexington, 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.