

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

33440

**1. PLACE OF DEATH**

County Jackson  
Township Ray  
City St. Louis

Registration District No. 399  
Primary Registration District No. 1002  
No. 3426 Wyandotte

File No. \_\_\_\_\_  
Registered No. 4210  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Michael N. Lauth

(a) Residence, No. 3426 Wyandotte St., 5 Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. 5 mos. 5 da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Mrs Mary Lauth

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1st 1855

7. AGE: YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 72 5 2

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Watchman  
(b) General nature of industry, business, or establishment in which employed (or employer) Municipality  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) N.Y.  
(STATE OR COUNTRY)

10. NAME OF FATHER J.N. Lauth

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Horgan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ireland  
(STATE OR COUNTRY)

14. INFORMANT Mrs Mary Lauth  
(Address) 3426 Wyandotte St

15. FILED 11/6 27 M. M. Cronin  
REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/4/27 1927

17. I HEREBY CERTIFY, That I attended deceased from 1927 to Nov 3rd, 1927  
that I last saw him alive on Nov 3rd, 1927, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Endocarditis Valvular  
Insufficiency

CONTRIBUTORY (SECONDARY) General Debility

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH? \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
(Signed) Calvin A Beard M. D.  
11/5, 1927 (Address) 532 Altman Bldg.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Marys Cmn DATE OF BURIAL 11/7/27 1927

20. UNDERTAKER H. J. Mayberry No ADDRESS City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT RECORD

