

DEC 22 1941
Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **ST. LOUIS MO**
(b) City or town **ST. LOUIS MO**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **LUTHERAN HOSPITAL D**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 MONTHS**
(Specify whether years, months or days) **28**
In this community **28**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **009 19 0 23**
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **1819 RUSSELL AVE**
(If rural, give location)
(e) Citizen of foreign country? **YES** (Yes or No)
If yes, name country **HUNGARY**

3. (a) PRINT FULL NAME **JOHN H. LAUB**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **DEC. 6 1896**
(Month) (Day) (Year)

8. AGE: Years **44** Months **10** Days **25** If less than one day hr. min.

9. Birthplace **HUNGARY**
(City, town, or county) (State or foreign country)

10. Usual occupation **BUILDING CONTRACTOR**

11. Industry or business.....

12. Name **JACOB LAUB**

13. Birthplace **HUNGARY**
(City, town, or county) (State or foreign country)

14. Maiden name **KATHERINE WELDER**
(City, town, or county) (State or foreign country)

15. Birthplace **HUNGARY**
(City, town, or county) (State or foreign country)

16. (a) Informant **PETER LAUB**

(b) Address **1819 RUSSELL AVE**

17. (a) **BURIAL** (b) Date thereof **NOV. 3, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **NEWSS PETER & PAUL**

18. (a) Signature of funeral director **Franklin & Son**

(b) Address **2906 Grand Ave**

19. (a) **NOV 2 1941** (b) **J F Bruck**
(Date received local health officer's certificate) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct 31** day **Oct.**
year **1941**, hour **2** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **May 22 1941** to **Oct. 31 1941**
that I last saw him alive on **Oct. 31 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **General Carcinoma of** Duration **2 mos.**
Ca. of Lung **5 mos.**

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations **None**
Of autopsy **None**

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature **Dr. Paul W. Welch** (M. D. or other) **0**
Address **3115 S. Grand** Date signed **10/24/41**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

Laird Milton Van Fossan....., Registered Apprentice No. *280*
working under my personal supervision.

Signed.....

Licensed Embalmer No. *1619*

P. O. Address *2906 Gravois*

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 this body is not embalmed, fact should be so stated above.