

S. No. 2
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7-5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

25050

FILED

JUL 23 1945

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 3.7

Primary Registration District No. 6076

Registrar's No. 1752

1. PLACE OF DEATH

(a) County St. Louis
(b) City or town Urbana
(c) Name of hospital or institution: St. Louis Training School
(d) Length of stay: In hospital or institution _____
In this community all his life since childhood

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Urbana
(d) Street No. Jefferson & Hall Road
(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME WILLIAM McLaughlin

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 Married
6. (b) Name of husband or wife Julia Mary McLaughlin 6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased November 2, 1880

8. AGE: Years 64 Months 8 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Hanibal, Mo (City, town, or county) (State or foreign country)

10. Usual occupation Hospital Attendant

11. Industry or business _____

MOTHER FATHER { 12. Name Ferdinand McLaughlin
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name Anna, nee Henry
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Julia Mary McLaughlin
(b) Address St. Louis Training School

17. (a) Burial (b) Date thereof 7/13/45
(c) Place: burial or cremation Friedens

18. (a) Signature of funeral director Stroot-Carroll
(b) Address 4600 Natural Bridge Ave.

19. (a) 7-12-1945 (b) E. M. Gorman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10 year 1945 hour 6.05 minute _____ A. M.

21. I hereby certify that I attended the deceased from during the last year 19____ to _____ 19____ that I last saw him alive on July 9 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis

Due to Arteriosclerosis

Due to Hypertension 94a

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

Major findings: Of operations _____ Of autopsy _____

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 Gregory M. Albrocks (M. D. or other) _____
Address St. Louis Training School Date signed 7.10.45

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

DEC 30 1945

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Ben E. Johnson*
Licensed Embalmer No. *1366*
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 this body is not embalmed, fact should be so stated above.

S. No. 2B
5M-3.45
1 X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug
Registrar's No. 175+2

Registration District No. 317 Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St Louis Training School
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether

In this community
years, months or days)

3. (a) PRINT FULL NAME Wm Mc Laughlin

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased M 2 19
(Month) (Day) (Year)

8. AGE: Years 65 Months 6 Days 10 If less than one day hr. NO min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant..... (b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a)..... (b)..... (Registrar's signature)

(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (If outside city or town limits, write "RURAL")

(d) Street No..... (If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day..... year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19..... that I last saw him..... alive on..... and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to.....

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

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

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..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

DEC 30 1945

1945

S-25050