

STANDARD CERTIFICATE OF DEATH

FILED AUG 18 1945

Registration District No. 217

Primary Registration District No. 6076

Registrar's No. 1217

1. PLACE OF DEATH:

(a) County ST LOUIS
(b) City or town NO RMANdy
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
OSULLIVAN NURSING Home #
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 YRS
(Specify whether years, months or days)
In this community 4 YRS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County CLU
(c) City or town ST LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 1114 CLARENDON
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

George B. Laschly

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M W

5. Color or race W

6. (a) Single, widowed, married, divorced W Y

6. (b) Name of husband or wife MARY JANE LASCHLY

6. (c) Age of husband or wife 18 years

7. Birth date of deceased JULY 4

1856
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

89

1

7

hr. min.

9. Birthplace

LEBANON

MO

(City, town, or county)

(State or foreign country)

10. Usual occupation

RETIRED MERCHANT

11. Industry or business

MOTHER FATHER

12. Name DAVID B LASCHLY

13. Birthplace OHIO

14. Maiden name SUSAN LINKENFELDER

15. Birthplace DO NOT KNOW

16. (a) Informant

Jace Baker

(b) Address 1114 CLARENDON ST LOUIS MO

17. (a)

REMOVAL

(b) Date thereof

8-12-45

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation MARSHALL MO

18. (a) Signature of funeral director

ORTMANN FUNERAL Home

(b) Address 2222 ACKLAND OVERLAND MO

19. (a)

8-14-45

(b)

G. B. M. [Signature]

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 11
year 1945 hour 8 P.M. minute M.

21. I hereby certify that I attended the deceased from 9/15/43
1943 to 8/10/45 1945

that I last saw h. 1 M alive on 8/10 1945
and that death occurred on the date and hour stated above

Immediate cause of death

Myocardial Infarction
Congestive Heart Failure
Senile

Duration

Due to

Due to

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 Orin Selms (M.D. or other) Do

Address 7320 S. Lamar Rd. Date signed 9/12/45

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

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..... *Al C Ostmann*

Licensed Embalmer No..... *3478*

P. O. Address:.....

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.