

No. 2
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DEPARTMENT OF COMMERCE - THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

11351

State File No. _____

FILED MAR 27 1946
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2565

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. Laclede Hotel
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles B. Lauer (Laure)
3. (b) If veteran, name war None 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 15th
1946 year hour 3 minute 30 M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Div
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

7. Birth date of deceased May 27, 1866
(Month) (Day) (Year)

Immediate cause of death _____
Hypostatic Pneumonia
Oedema of Brain; Uremia
Due to _____
Due to _____

8. AGE: Years 79 Months 9 Days 10
If less than one day _____ hr. _____ min.
9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

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

10. Usual occupation Retired Plumber
11. Industry or business _____
12. Name William Lauer 9
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

14. Maiden name Micalina Hansen 4
15. Birthplace Denmark 4
(City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Beatrice McKinney
(b) Address 4421 Arco
17. (a) Cremation (b) Date thereof 3-19-46
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation Valhalla Crematory
18. (a) Signature of funeral director Southern Funeral Home
6322 S. Grand Blvd.
(b) Address _____
19. (a) MAR 18 1946 (Date received local registrar) J. F. Bredesh (Registrar's signature)

While at work? _____ (Specify type of place)
(b) Means of injury 3
23. Signature W. H. Perry (M. D. or other)
Address 1212 1/2 Chestnut Date signed 3/18/46

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

10263

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..... *J. W. Dumble* ..
Licensed Embalmer No. *36573* ..
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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
25657
Registrar's No. _____

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(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 Charles B. Lanier (Lanier)

3. (b) If veteran, name war none 3. (c) Social Security No. _____

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

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

7. Birth date of deceased May 27 1906
(Month) (Day) (Year)

8. AGE: Years 79 Months _____ Days _____ If less than one day _____ hr. _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) J. J. Buresch
(Date received local registrar) (Registrar's signature)

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 May Day 19 -
year 1946 hour _____ minute _____ M.

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

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

Major findings:
Of operations _____
Of autopsy _____

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) _____
Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

APR 5 1946

11351