No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33316

FILED SEP 23 1947

Registration District No. 3

Primary Registration District No. 6076

Registrar's No. 1957

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2255 days (Specify whether
In this community 30 years
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. 2639 Accomac
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME LaRose, Paul Newman
3. (b) If veteran, name war
3. (c) Social Security No. 494-07-5628
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Jean McClaskey LaRose
6. (c) Age of husband or wife if alive years
7. Birth date of deceased October (Month) 2 (Day) 1903 (Year)

8. AGE:

Years	Months	Days	If less than one day
43	11	13	hr. min.

9. Birthplace Flat River (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Wood Heel Worker
11. Industry or business
FATHER
12. Name Frank LaRose
13. Birthplace Bonne Terre (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Emma Billington
15. Birthplace Bonne Terre (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Matthews Cem.
18. (a) Signature of funeral director McLaughlin
(b) Address 2301 Lafayette
19. (a) 9-18-47 (Date received local registrar) (b) Cecil A. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 15
year 1947 hour 2 minute 10 A. M.
21. I hereby certify that I attended the deceased from 1-3- 1947 to 9-15 1947
that I last saw him alive on 9-15 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	7 yrs. (??)
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

13b

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury
Signature E.W. Zebrinski (M. D. or other)
Address Robert Koch Hospital Date signed 9-15-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

E.W. Zebrinski

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 C. W. Cooper

Licensed Embalmer No. 3830

P. O. Address 2301 Lafayette

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.