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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 11 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14407**
Registrar's No. **4134**

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis
(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:
Washington Blvd. Clinic
(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

Larry McLaskey

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex M.
5. Color or race Wh.

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 November 9 1947
(Month) (Day) (Year)

8. AGE: 5 Years 5 Months 21 Days
0 : 5 : 21
hr. min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Dean McLaskey

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

14. Maiden name Ruth Rotramel

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

16. (a) Informant Dean McLaskey

(b) Address West Frankfort, Ill.

17. (a) Removal (b) Date thereof 5-1-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Frankfort, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAY 1 1948 (b) J. F. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Franklin
(c) City or town West Frankfort
(If outside city or town limits, write "RURAL")
(d) Street No. N.R. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1948 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from April 30 1948 to April 30 1948;
that I last saw him alive on April 30 1948
and that death occurred on the date and hour stated above.

Immediate cause of death anemia
renal failure

Due to long standing anemias
multiple g.v. tract

Due to double ectopic pyonephrosis
with abscess

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

Major findings:
Of operations as above
Of autopsy as above

Duration of illness

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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 _____

23. Signature David D. [Signature] (M. D. or other) _____
Address 337 N. Euclid Date signed 4-30-48

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

Geertus W. Rutledge

Licensed Embalmer No.

4327

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.