

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39718**

FILED JAN 4 1951

BIRTH MO. 1/18 REG. DIST. NO. 2 PRIMARY REG. DIST. NO. 4009 Registrar's No. 490

021

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

1. PLACE OF DEATH a. COUNTY ANDREW		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY Andrew	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAVANNAH, MO.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAVANNAH 0021	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) Market St.	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH b. (Middle) EDWARD c. (Last) LAUBER			4. DATE OF DEATH (Month) (Day) (Year) DEC. 25 1950		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH NOV. 19-1860	9. AGE (In years last birthday) 90	10. YEARS 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) SAVANNAH MO		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME ALBERT LAUBER	13b. MOTHER'S MAIDEN NAME MARGRETE SHAFER	14. NAME OF HUSBAND OR WIFE IDA MAY LAUBER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Ida May Lauber Savannah Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-Vascular Renal Disease		INTELLECT BETWEEN ONSET AND DEATH 1 year.
	DUE TO (b) Sen. Arterio-sclerosis.		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			445X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-27, 1949**, to **12-25, 1950**, that I last saw the deceased alive on **12-25, 1950** and that death occurred at **7:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Libert B. Kelley, M.D.	23b. ADDRESS Savannah, Mo.	23c. DATE SIGNED 12-26-50
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12-28-1950	24c. NAME OF CEMETERY OR CREMATORY SAVANNAH
		24d. LOCATION (City; town, or county) (State) SAVANNAH MO

DATE REC'D BY LOCAL REG. 12-28-50	REGISTRAR'S SIGNATURE William Sparks	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Breit Funeral Home Savannah
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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.....

..... Student Embalmer No.

working under my personal supervision.

Signed E. C. Breit.....

Signed.....
Student Embalmer

Licensed Embalmer No. 2650.....

P. O. Address Swanwick 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.