

FILED NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35322

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9994

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Marian Hospital		e. STREET ADDRESS (If rural, give location) 3201 Eads	

3. NAME OF DECEASED (Type or Print) a. (First) August b. (Middle) LaRose c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 10-11-51		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 3/19/1875	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mo.	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Felix LaRose	13b. MOTHER'S MAIDEN NAME Nancy Farley	14. NAME OF HUSBAND OR WIFE Agnes McMahon LaRose
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Helen Hausmann	ADDRESS 3201 Eads Ave.
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Yes
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>mitral clumping</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>old age</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? HOX

22. I hereby certify that I attended the deceased from Oct 4, 1951, to Oct 11, 1951, that I last saw the deceased alive on Oct 11, 1951, and that death occurred at 7:10p m., from the causes and on the date stated above.

23a. SIGNATURE <u>JTS Ryne</u>	(Degree or title) M.D.	23b. ADDRESS 2752 Schermer	23c. DATE SIGNED Oct 25
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/15/51	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE BY LOCAL REGISTRAR'S SIGNATURE Oct 13 1951 <u>J. Earl Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Schermer</u>	ADDRESS 3125 Lafayette Ave.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2752 at Cleveland
Amy Lane

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.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 4014

P. O. Address 3125 Lakewood

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.