

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11026**BIRTH NO. **FILED APR 8 1952**REG. DIST. NO. **317**PRIMARY REG. DIST. NO. **6076**Registrar's No. **820**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Jennings	
b. CITY (If outside corporate limits, write RURAL and give township) Jennings		c. LENGTH OF STAY (In this place) 2 Yrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2125 McLaren		d. STREET ADDRESS (If rural, give location) 2125 McLaren	
3. NAME OF DECEASED (Type or Print) a. (First) Adelaide b. (Middle) c. (Last) Laing		4. DATE OF DEATH (Month) (Day) (Year) March 26 1952	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH June 22 1874
9. AGE (In years last birthday) 77		# UNDER 1 YEAR Months Days	# UNDER 1 MIN. Hours Min.
10a. USUAL OCCUPATION (Give kind of work) house work		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Herman Laing		13b. MOTHER'S MAIDEN NAME Adelaide Lampe	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. F.J. Schroeder 2125 McLaren.
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Hypertension	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Heart Disease	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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 331X
22. I hereby certify that I attended the deceased from Mar. 24, 1952 to Mar 26, 1952 , that I last saw the deceased alive on Mar 26, 1952 , and that death occurred at 4:30 PM from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Eugene Kahler M.D.		23b. ADDRESS	23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/29/52	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
DATE REC'D BY LOCAL REG. 3-27-52		REGISTRAR'S SIGNATURE Herbert R. Donke MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan's 2849 No. Euclid Ave.

SW (Licensed Embalmer's Statement on Reverse Side)

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

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Student Embalmer No.

Licensed Embalmer No. 3553

P. O. Address.....

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.