

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3381**
Registrar's No. **0803**

FILED FEB 3 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2049	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If rural, give location) 1423 Louisville Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Amob		b. (Middle) J.		c. (Last) LaPlant	
4. DATE OF DEATH (Month) (Day) (Year) Jan. 22 1953		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Sept. 2 1884		9. AGE (In years last birthday) 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Shop Owner		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Genoa Ohio	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Joseph LaPlant		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Rose M. LaPlant		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Rose LaPlant		ADDRESS 1423 Louisville Ave.			
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) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH Some days	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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"/>	
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? 4-201	
22. I hereby certify that I attended the deceased from 1-21-1952 to 1-22-1953 , that I last saw the deceased alive on 1-22-1953 , and that death occurred at 6:30 PM from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Alvin M. Males M.D.		23b. ADDRESS 819 University Club Bldg		23c. DATE SIGNED 1-23-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/26/53		24c. NAME OF CEMETERY OR CREMATORY Calvary	
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Sullivan's		ADDRESS 2849 N. Euclid Ave.	
DATE REC'D BY LOCAL REG. JAN 23 1953		REGISTRAR'S SIGNATURE Carl Smith MD			

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Robert M Murray*

Licensed Embalmer No. *3749*

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.