

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

 State File No. **15913**  
**4450**

FILED MAY 14 1953

BIRTH NO. \_\_\_\_\_

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

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>Little Sisters of Poor</b>				e. STREET ADDRESS (If rural, give location) <b>3400 S. Grand Blvd. 2169</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Frederick</b>			b. (Middle)		c. (Last) <b>La Tour</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>April 29, 1953</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>December 15, 1860</b>		9. AGE (In years last birthday), Months, Days, Hours, Min. <b>92 4 14</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Upholsterer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>New York /</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Joseph La Tour</b>			13b. MOTHER'S MAIDEN NAME <b>Margaret Gonary</b>			14. NAME OF HUSBAND OR WIFE <b>Josephine</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Sister Henry 3400 S. Grand Blvd.</b>				
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) <b>Cerebrovascular degenerative disease</b> ANTECEDENT CAUSES <b>due to (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> DUE TO (c) <b>Reflexo. Spasms</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>1 yr</b>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>442x</b>					
22. I hereby certify that I attended the deceased from <b>12/15/53</b> to <b>4/29/53</b> , that I last saw the deceased alive on <b>4/26/53</b> , and that death occurred at <b>3:30A</b> m., from the causes and on the date stated above.									
23a. SIGNATURE (Name or title) <b>Earl Smith MD</b>				23b. ADDRESS <b>607 N. Grand</b>				23c. DATE SIGNED <b>4/30/53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>5/2/53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>			
DATE RECD BY LOCAL REG. <b>APR 30 1953</b>		REGISTRAR'S SIGNATURE <b>Earl Smith MD</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John H. Gebken Sons 2630 Gravois Ave.</b>				

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

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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..

Student.....  
Signature of Student Embalmer

Signed..... *Robert F. Gebbard*

Licensed Embalmer No..... 4144

P. O. Address 2630 Gravois Ave.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.