

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5833

State File No.

FILED MAR 1 1955

BIRTH NO. _____ REG. DIST. NO. 290 PRIMARY REG. DIST. NO. 5985 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY Pulaski		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town or township) Fort Leonard Wood		c. CITY OR TOWN Warson Woods	
c. LENGTH OF STAY (in this place) 12 days		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 US Army Hospital		f. STREET ADDRESS (If rural, give location) 4 Ridgeline Drive	

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Richard c. (Last) Lages		4. DATE OF DEATH (Month) (Day) (Year) February 23, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7 April 1914
9. AGE (In years last birthday) 40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist	
10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (City and State or Foreign Country) Poplar Bluff, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME Charles R. Lages	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Alice Geradine Lages
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 13 July 53 to date Unknown	17. INDEMNITY SIGNATURE OR NAME US Army Hospital ROBERT STALEY, LT MSC Ft Leonard Wood, Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Septicemia		ANTECEDENT CAUSES		7 days	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Empyema of right thorax		8 days	
		DUE TO (c) Subphrenic abscess, right		8 days	
II. OTHER SIGNIFICANT CONDITIONS		Extensive abdominal injuries			
Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION 11 Feb 55	19b. MAJOR FINDINGS OF OPERATION Stellate laceration of liver, right lobe	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway #66	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4 miles E of Junction County Route D and Hwy 66 Franklin Missouri
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Feb 11, 1955 5:15p	21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Auto accident

22. I hereby certify that I attended the deceased from 11 Feb 19 55, to 23 February 19 55, that I last saw the deceased alive on 23 February 55, and that death occurred at 10:45a m., from the causes and on the date stated above.

23a. SIGNATURE R. W. BUCHANAN, Major, MC	23b. ADDRESS US Army Hospital Fort Leonard Wood, Missouri	23c. DATE SIGNED 23 Feb 1955
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2/24/55	24c. NAME OF CEMETERY OR CREMATORY Unknown 458	24d. LOCATION (City, town, or county) (State) Kirkwood, Missouri
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DATE REC'D BY LOCAL REG. 2-24-55	REGISTRAR'S SIGNATURE Carla M. Anderson	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HELGES FUNERAL HOME CROCKER, MO
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(Licensed Embalmer's Statement on Reverse Side)

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

55-78-8
55-78-8

1955
5
1956
JUN 7
MAR 31 1955

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 *Clarence D. Rose*

Licensed Embalmer No. *4296*
P. O. Address *Waynesville*

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.