

FILED APR 5 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9856

State File No.

2777

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 Missouri				b. COUNTY Jefferson		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN Crystal City		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 St. John's Hospital				STREET ADDRESS (If rural, give location) 110 Church St.				0501		
3. NAME OF DECEASED (Type or Print)			a. (First) Adam			b. (Middle) Louis				
			c. (Last) LaRose			4. DATE OF DEATH (Month) (Day) (Year) March 28, 1955				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb. 5, 1884		9. AGE (In years last birthday) 71		
						IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Glassworker			10b. KIND OF BUSINESS OR INDUSTRY Glass Co.			11. BIRTHPLACE (City and State or Foreign Country) Bloomsdale, Mo.			12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Dicale LaRose			13b. MOTHER'S MAIDEN NAME Mary McRice			14. NAME OF HUSBAND OR WIFE Julia				
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. 489-03-3809			17. INFORMANT'S SIGNATURE OR NAME Mrs. Adam LaRose			ADDRESS Crystal City, Mo.	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 5 weeks		
				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphatic Sarcoma						
				ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbidity 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 checked="" 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? 2001						
22. I hereby certify that I attended the deceased from 10-30 , 19 54 , to 3-28 , 19 55 , that I last saw the deceased alive on 3-17 , 19 55 , and that death occurred at 3:00a m., from the causes and on the date stated above.										
23a. SIGNATURE Carl Smith			23b. ADDRESS (Street or title) 18th Rensselaer			23c. DATE SIGNED 3-28-55				
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3-28-55		24c. NAME OF CEMETERY OR CREMATORY Catholic		24d. LOCATION (City, town, or county) (State) Festus, Mo.				
DATE REC'D BY LOCAL REG. MAR 28 1955			REGISTRAR'S SIGNATURE Carl Smith Mo			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Vinyard Funeral Home, Festus, Mo.				

(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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *J. W. Benkley*
Licensed Embalmer No. *365*
P. O. Address *St. Louis*

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.