

FILED SEP 13 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28366

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 2036

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri.</u> b. COUNTY <u>St. Louis.</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Clayton's</u>	c. LENGTH OF STAY (in this place) <u>3 yrs.</u>	c. CITY OR TOWN <u>Clayton?</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6357 Clayton Ad.</u>		e. STREET ADDRESS (If rural, give location) <u>6357 Clayton Rd. 4002</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Henry</u> b. (Middle) <u>Lewis</u> c. (Last) <u>Lauscher</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>August 30 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married.</u>	8. DATE OF BIRTH <u>Jan. 27, 1884</u>	9. AGE (In years) (last birthday) <u>71</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 4 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Artificial Flowers</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Germany</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Gladys I. Lauscher</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Gladys Lauscher, 6357 Clayton Rd.</u>

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of the esophagus</u>		
	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. <u>150x</u>		

19a. DATE OF OPERATION <u>March 1955</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of the esophagus with metastases</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis, Mo.</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Sept. 1954, to Aug. 30, 1955, that I last saw the deceased alive on Aug. 30, 1955, and that death occurred at 7:05 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Herbert C. Meynard M.D.</u>	23b. ADDRESS <u>3720 Washington Blvd.</u>	23c. DATE SIGNED <u>Aug. 30, 1955</u>
24a. FULL NAME OF REGISTRAR (Type or Print) <u>Ron Grogan</u>	24b. DATE <u>9-2-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon</u>
		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>

DATE REC'D BY LOCAL REG. <u>8/31/55</u>	REGISTRAR'S SIGNATURE <u>Herbert C. Meynard</u>	FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>	ADDRESS <u>4700 Washington Blvd.</u>
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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 *Paul A. Wachtel*.....

Licensed Embalmer No. *278*.....

P. O. Address *Houston*.....

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.