

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34934**  
**8733**

FILED OCT 24 1955

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) <b>St. Louis, Missouri</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>St. Louis</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> <b>4</b>	
		6 STREET ADDRESS (If rural, give location) <b>5867 Theodosia</b> <b>20610</b>	

3. NAME OF DECEASED (Type or Print) <b>JOHN</b>	a. (First)	b. (Middle)	c. (Last) <b>LAAGER</b>	4. DATE OF DEATH <b>OCT. 5, 1955.</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Aug. 15, 1873</b>	9. AGE (in years last birthday) <b>82</b>	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone Cutter</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Carlinville, Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Gabriel Laager</b>	13b. MOTHER'S MAIDEN NAME <b>Rosa Rossmann</b>	14. NAME OF HUSBAND OR WIFE <b>Minnie</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Minnie Hall, 111 Wallace Ave.</b>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION <b>Dupo, Ill.</b>		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	<b>Incredible Hernia leading to Shock</b>		
ANTECEDENT CAUSES	DUE TO (b) <b>Uremia</b>		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) <b>Carcinoma of the Bladder</b>		
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	<b>181x</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 9-24- 19 55, to 10-5- 1955, that I last saw the deceased alive on 10-5- 1955, and that death occurred at 3:30a m., from the causes and on the date stated above.

23a. SIGNATURE <b>Fred Mortensen</b> (Degree or title) <b>MD</b>	23b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	23c. DATE SIGNED <b>10-5-55.</b>
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24a. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>	24b. DATE <b>10-7-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
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DATE REC'D BY LOCAL REG. <b>OCT 6 1955</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>	ADDRESS <b>4700 Washington Blvd.</b>
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(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 *John Binkley*.....  
Licensed Embalmer No. *365*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.