

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28719

STATE FILE NUMBER

FILED AUG 24 1956

318

1003

6762

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE				b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis 27th				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hospital #1				Length of stay in 1b		d. STREET ADDRESS 3725 Pennsylvania				Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Joseph LaBee						4. DATE OF DEATH Month Day Year July 17, 1956						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 17 1891		9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis				12. CITIZEN OR WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jos. H. LaBee						14. MOTHER'S MAIDEN NAME Julie Morris						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. 494-03-9370		17. INFORMANT Address Anna L. LaBee 3725 Penn.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis, pulmonary, active, far advanced										INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b)		
										DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY a. m. p. m.												
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION			COUNTY		STATE	
21. I attended the deceased from 7-11-56 to 7-17-56 and last saw her him alive on 7-17-56 Death occurred at 3:00a m on the date stated above; and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE (Degree or title) Charles E. Hagan, M.D.						22b. ADDRESS 1515 Lafayette			22c. DATE SIGNED 7-18-56			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-20-56		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope		23d. LOCATION (City, town, or county) St. Louis Co Mo			(State)			
24. FUNERAL DIRECTOR ADDRESS JOS. P. FENDLER JR. 7128 MICHIGAN				25. DATE RECD. BY LOCAL REG. JUL 19 1956		26. REGISTRAR'S SIGNATURE Carl Smith MO						

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare public service
 300 1-56
 Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Pocho*

Licensed Embalmer No. *30*
P. O. Address *7128 Me*

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.