

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 18 1956

318

1003

State File No. 43388
Registrar's No. 10725

BIRTH NO. _____		REG. DIST. NO. _____		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 <u>MO</u> b. COUNTY <u>JEFF</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>		c. LENGTH OF STAY (in this place) <u>1 year</u>		c. CITY OR TOWN <u>DE SOTO</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>FIRMAN DELOGE HOSP</u>				e. STREET ADDRESS (If rural, give location) <u>1501 N. Fourth</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>HELEN</u> b. (Middle) <u>A</u> c. (Last) <u>LASCH</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 23, 1956</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>Aug 20, 1888</u>	
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Hours _____ Mins. _____		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ANTONIA, MO</u>			
13a. FATHER'S NAME <u>JOHN SCHNEIDER</u> <u>CHARLES LASCH</u>			13b. MOTHER'S MAIDEN NAME <u>BARBARA KOEING</u>		14. NAME OF HUSBAND OR WIFE <u>CHARLES LASCH</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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>FELIX LASCH DE SOTO, MO</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Peripheral vas. collapse</u> <u>Septicemia</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Septicemia</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Lower nephron nephrosis</u> <u>Lower nephron nephrosis</u> Conditions contributing to the death but not related to the disease or condition causing death. <u>liver abscess, adrenal cortical atrophy</u>					INTERVAL BETWEEN ONSET AND DEATH <u>053.4</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Liver abscess; adrenal cortical ??</u>					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) _____		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 <u>10-26-56</u> , 19 <u>56</u> , to <u>11-23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-23-56</u> , and that death occurred at <u>2060 m.</u> , from the causes and on the date stated above <u>11-23-56</u>							
23a. SIGNATURE <u>Martin L. Howard</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Firmin Desloge Hosp.</u>		23c. DATE SIGNED <u>11-23-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>Nov 26, 1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		24d. LOCATION (City, town, or county) (State) <u>DE SOTO MO</u>	
DATE REC'D BY LOCAL REG. <u>NOV 26 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>MAHON Funeral Home De Soto MO</u>			

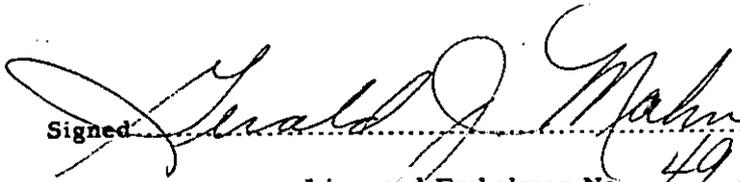
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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



Licensed Embalmer No. 49

P. O. Address D. S. S. Co.

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.