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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED APR 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 10600

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2993

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSP. #1. — Length of stay in 1b: 25 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN: ST. LOUIS, MO. — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2639 CAROLINE — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First CLARENCE Middle Last LAXTON
4. DATE OF DEATH: Month MAR. Day 11, Year 1957
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 9, 1889
9. AGE (In years last birthday): 67 — 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): unknown
10b. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (City and state or country): MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN
14. MOTHER'S MAIDEN NAME: UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: ST. LOUIS CITY HOSP. #1. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage from Gastrointestinal tract
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Unknown Cause
DUE TO (c) Possible G-I malignancy
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 159X
INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 2/26/57 11:45 A.M. to 3/11/57 and last saw her/him alive on 3/11/57
Death occurred at m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Thomas C. Roach M.D.
22b. ADDRESS: 1515 LAFAYETTE AVE.
22c. DATE SIGNED: 3/12/57
23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: 3-30-57
23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.
24. FUNERAL DIRECTOR: Rowland-Aker — ADDRESS: 4044 Manchester
25. DATE RECD. BY LOCAL REG.: MAR 28 '57
26. REGISTRAR'S SIGNATURE: J Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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