

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46835
STATE FILE NUMBER

FILED JAN 15 1958

Registration District No. 217 Primary Registration District No. 500 Registrar's No. 3339

1. PLACE OF DEATH a. COUNTY ST. LOUIS				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS KOCH		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ROBERT KOCH HOSP.				Length of stay in lb 27 days		d. STREET ADDRESS (If outside, give location) 5231 WASHINGTON	
3. NAME OF DECEASED (Type or print) First JAMES Middle Last LAUGHLIN				4. DATE OF DEATH Month 12 Day 31 Year 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6-14-87	
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK				10b. KIND OF BUSINESS OR INDUSTRY Office Work		11. BIRTHPLACE (City and state or country) KANSAS	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME TIM LAUGHLIN				14. MOTHER'S MAIDEN NAME Layina Motz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No NONE		16. SOCIAL SECURITY NO. 493-20-8151		17. INFORMANT Address ROBERT KOCH HOSPITAL, KOCH, MO.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA ? Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 493X						INTERVAL BETWEEN ONSET AND DEATH	
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? 2 YES <input type="checkbox"/> NO <input checked="" 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 Hour _____ 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 12-4-57 to 12-31-57 and last saw her/him alive on 12-31-57 Death occurred at 10:25 P on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Bernard Swamen M.D.				22b. ADDRESS Koch Hosp, Koch, Mo		22c. DATE SIGNED 1-1-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Jan. 3, 1958		23c. NAME OF CEMETERY OR CREMATORY Local Cem.		23d. LOCATION (City, town, or county) (State) Waterloo, Illinois	
24. FUNERAL DIRECTOR ADDRESS Ambruster Mortuary, 6633 Clayton Rd.				25. DATE RECD. BY LOCAL REG. Jan 2, 1958		26. REGISTRAR'S SIGNATURE Herbert H. Donche M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, & Welfare
Public Service
S. 300
Y. 1-1-58
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.
Securing the medical certification in this specific manner required by 193.140 MoRS 1949.

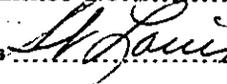
STATEMENT BY LICENSED EMBALMER

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. 47

P. O. Address.....


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.