

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011977
STATE FILE NUMBER

FILED MAR 19 1958

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2459**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN West St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MISS. Pac. Hosp. Ass.		STREET ADDRESS (If outside, give location) 6013 Garesche	
3. NAME OF DECEASED First LYNN Middle MAY Last McLaughlin		4. DATE OF DEATH Month 2 Day 27 Year 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (City and state or country) Ill.
13a. FATHER'S NAME Thomas Collins		13b. MOTHER'S MAIDEN NAME Lucy Harmon	
14. NAME OF HUSBAND OR WIFE John F. McLaughlin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT John McLaughlin Address 6013 Garesche Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertensive arterial disease years DUE TO (c) Diabetes Mellitus 33 2x			INTERVAL BETWEEN ONSET AND DEATH 7 days
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 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 2-24-58 to 2-27-58 and last saw her alive on 2-26-58 Death occurred 7:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE L. B. Harrison M.D. (Degree or title)	
22b. ADDRESS 1755 So GRAND		22c. DATE SIGNED 2-27-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 3/3/58	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Mo.
24. FUNERAL DIRECTOR Buchholz Mortuary 5967 W. Florissant ADDRESS		25. DATE RECD. BY LOCAL REG. FEB 28 '58	26. REGISTRAR'S SIGNATURE Carl Smith MD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Wilfred W. Buschke*

Licensed Embalmer No. *4551* -

P. O. Address. *St. Louis*

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.