

Health, & Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030666  
STATE FILE NUMBER

FILED SEP 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8601

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		Length of stay in 1b 62 yrs. 2 1/2	d. STREET ADDRESS (If outside, give location) 7011 Sutherland		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) OTTO A LAUX			4. DATE OF DEATH Month Day Year September 4, 1958		
5. SEX Male <input checked="" type="checkbox"/>	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 July 23, 1896		9. AGE (In years last birthday) 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Operator		10b. KIND OF BUSINESS OR INDUSTRY Public Trans. Co.	11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Peter August Laux		13b. MOTHER'S MAIDEN NAME Augusta Flatmann		14. NAME OF HUSBAND OR WIFE Mrs. Mildred Brenner Laux	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I		16. SOCIAL SECURITY NO. 494-01-1298	17. INFORMANT Address Mrs. Mildred B. Laux, 7011 Sutherland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Brainogenic Ca of Lung</i>					INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) <i>162.1</i>					
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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 <i>4-1-58</i> to <i>9-4-58</i> and last saw <sup>her</sup> him alive on <i>9-3-58</i> Death occurred at <i>5:45 A.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Carl J. Smith M.D.</i> (Degree or title)		22b. ADDRESS <i>18th. Highway</i>		22c. DATE SIGNED <i>9-5-58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Sept. 6, 1958		23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery	
				23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri.	
24. FUNERAL DIRECTOR ADDRESS Beiderwieden F.H.Inc., 1936 St. Louis			25. DATE RECD. BY LOCAL REG. SEP 5 1958		26. REGISTRAR'S SIGNATURE <i>Carl J. Smith M.D.</i>

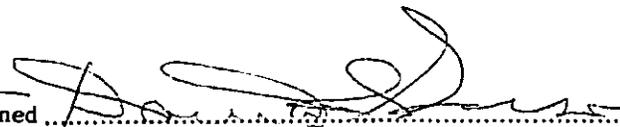
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

...disease in Part I must be causally related.

12:30 - 5:00  
X  
Sept  
24th

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 \_\_\_\_\_ Signed  \_\_\_\_\_  
Signature of Student Embalmer

Licensed Embalmer No. 4570  
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.