

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007339

STATE FILE NUMBER

FILED MAR 2 1959

Registration District No.

Primary Registration District No.

Registrar's No. 1598

300
-57

1. PLACE OF DEATH a. COUNTY		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) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Length of stay in lb 12 1/2 yrs.	d. STREET ADDRESS (If outside, give location) 827 Howard St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ROSEMARY Last La Boo		4. DATE OF DEATH Month 2 Day 11 Year 59
---	--	--

5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/91	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
------------------	---------------------------	---	-----------------------------	---------------------------------------	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during past 12 months, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY LAUNDRY WORKER	11. BIRTHPLACE (City and state or country) Minn.	12. CITIZEN OF WHAT COUNTRY? USA
--	---	---	-------------------------------------

13a. FATHER'S NAME John Jos. La Boo	13b. MOTHER'S MAIDEN NAME Nora Church	14. NAME OF HUSBAND OR WIFE --
--	--	-----------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 496-18-7633A	17. INFORMANT JOSEPH LABOO Address 1921 No MARKET
---	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rt. Middle Cerebral Artery Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 wks.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hypertensive Cardiovascular Dis.	12 yrs.
	DUE TO (c) Generalized Arteriosclerosis	12 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443X		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	--

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 8-6-46 to 2-11-59 and last saw her/him alive on 2-11-59 Death occurred at 5:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) John W. Beckham, M.D.	22b. ADDRESS 5800 Arsenal	22c. DATE SIGNED 2/13/59
---	------------------------------	-----------------------------

23a. BURIAL, CREMATION, RE interment CREMATION	23b. DATE 2/14/59	23c. NAME OF CEMETERY OR CREMATORY MISSOURI CREMATORY	23d. LOCATION (City, town, or county) (State) ST LOUIS Mo.
---	----------------------	--	---

24. FUNERAL DIRECTOR J L ZIEGENHEIN & SONS ADDRESS 7027 GRAVOIS	25. DATE RECD. BY LOCAL REG. FEB 14 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
---	--	---

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 No Embalming, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed E. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gravois

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.