

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019373  
STATE FILE NUMBER

24205  
Registration No.

FILED MAY 18 1959 Registration District No. Primary Registration District No.

300  
-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Anthony Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>4638 Michigan</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louis B. Laux</b>		4. DATE OF DEATH Month Day Year <b>April 28, 1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jul. 23, 1896</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>
13a. FATHER'S NAME <b>Charles Laux</b>		14. NAME OF HUSBAND OR WIFE <b>Clara C. Laux</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>494-10-6859</b>	17. INFORMANT Address <b>Clara C. Laux, 4638 Michigan Ave.,</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral apoplexy</b> DUE TO (b) <b>Hypertensive Heart Disease</b> DUE TO (c) <b>with arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 yrs</b>
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.) <b>443 X</b>	
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 <b>Jan. '55</b> to <b>Apr. 28 '59</b> and last saw him alive on <b>April 28-59</b> Death occurred at <b>830 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Declarant or title) <b>George A. O'Sullivan, M.D.</b>		22b. ADDRESS <b>7629 Ivory Ave.</b>	
22c. DATE SIGNED <b>4-29-59</b>			
23a. BURIAL, CREMATION, REMOVAL <b>removal</b>		23b. DATE <b>5-1-59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Lemay 23, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Southern Funeral Home 6322 S. Grand Blvd., St. Louis, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>APR 30 '59</b>	
26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

ALL diseases in Part I must be causally related.

PL 2-0149

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 *David Van Tassan* .....

Licensed Embalmer No. *4242* .....

P. O. Address *St Louis Mo* .....

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.