

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS SEP 16 1959**

**59-034018**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 8084**

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| 1. PLACE OF DEATH<br>a. COUNTY _____   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MISSOURI</u> COUNTY _____ |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>ST. LOUIS</u>                      |  | Length of stay in 1b<br><u>55 YRS.</u>   | c. CITY OR TOWN <u>ST. LOUIS</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>INCARNATE-WORD-HOSP.</u> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><u>3433- OREGON- AV.</u><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>CLARA LAUBERSHEIMER</u>  |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><u>AUG. 30<sup>TH</sup> 1959</u> |   |   |
| 5. SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3-27-1888</u>                                   | 9. AGE (last birthday)<br><u>71 YRS.</u>                            | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETIRED WARDROBE-MISTRESS</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>MUNICIPAL-OPERA</u>   | 11. BIRTHPLACE (City and state or country)<br><u>PIERCE-CITY-MO.</u>   | 12. CITIZEN OF WHAT COUNTRY<br><u>U. S. A.</u>                      |   |
| 13a. FATHER'S NAME<br><u>JOHN-DERKOSKI</u>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>SUSAN-KENSKI</u>  |  | 14. NAME OF HUSBAND OR WIFE<br><u>PETER-P. LAUBERSHEIMER (DECD)</u> |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>           |                                  | 16. SOCIAL SECURITY NO.<br><u>489-05-2535</u>   | 17. INFORMANT Address<br><u>KATHERYNE-BURGHERR= 3433-OREGON-AV.</u>    |   |   |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |  | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>  |  | <u>6 months</u>                  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.               | <del>MUXJX</del> <u>Cirrhosis of the Liver</u> | <u>unknown</u>                   |
|  | <del>MUXJX</del> <u>Esophageal varices</u>     | <u>"</u>                         |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |
|---|--|---|--|

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|---|---|--|-------|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____                       | 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 April 7, 1959 to August 30, 1959 last saw her him alive on August 30, 1959  
 Death occurred at 3:00 P. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title)<br><u>Mrs. Louis M.D.</u>        | 22b. ADDRESS<br><u>4145 a South Grand Blvd.</u> | 22c. DATE SIGNED<br><u>8-31-59</u>                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>REMOVAL</u>       | 23b. DATE<br><u>SEPT. 2<sup>ND</sup> 1959.</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>MT. HOPE - CEMETERY</u> |
| 23d. LOCATION (City, town, or county) (State)<br><u>LEMAY MO.</u> |   |  |

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| 24. FUNERAL DIRECTOR ADDRESS<br><u>Rockland Und. Co. 1827-HOGAN-ST.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>AUG 31 1959</u> | 26. REGISTRAR'S SIGNATURE<br><u>Earl Smith, M.D.</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*Elton R. H. Remel*

Licensed Embalmer No. 4283

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.