

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS OCT 23 1959**

**59-037839**

**2 9467**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

UNEMENDED

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b _____ c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____ c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>4639 Delor St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JOHN</b> Middle <b>L.</b> Last <b>McLAUGHLIN</b>			<b>4. DATE OF DEATH</b> Month <b>Oct.</b> Day <b>15</b> Year <b>1959</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10-30-1880</b>	<b>9. AGE (last birthday)</b> <b>78</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Cutter (Retired) Rice</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Stix Co.</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Napoleon, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
<b>13a. FATHER'S NAME</b> <b>James McLaughlin</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Hanna Unknown</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Adele C. McLaughlin</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b> <b>None</b>		<b>16. SOCIAL SECURITY NO.</b> <b>492-03-4214</b>	<b>17. INFORMANT</b> Address <b>Adele C. McLaughlin 4639 Delor St.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>aden Carcinoma of rectum - (postoperative 48 hrs at death)</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>				
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____	<b>STATE</b> _____	
<b>21. I attended the deceased from</b> <b>October 7, 1959</b> , to <b>Oct. 15, 1959</b> and last saw him alive on <b>Oct 15, 1959</b> . Death occurred at <b>9:00 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> (Degree or title) <b>Sam Schneider MD</b>			<b>22b. ADDRESS</b> <b>4652 Maryland</b>		<b>22c. DATE SIGNED</b> <b>10/15/59</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>	<b>23b. DATE</b> <b>10-17-1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Resurrection Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis Co. Mo.</b>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Kriegshauser 4228 S. Kingshighway</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>OCT 15 '59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Earl Smith, M.D.</b>		

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 Ernest A. McArthur

Licensed Embalmer No. 3024

P. O. Address \_\_\_\_\_

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.