

FILED VS AUG 26 1960

-60-022512  
STATE FILE NUMBER

ENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8305**

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 <b>ST. LOUIS, MISSOURI</b>		a. STATE <b>Missouri</b>	b. COUNTY <b>Callaway</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		c. CITY OR TOWN <b>Auxvasse</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Route # 1</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>LOUISE</b> Middle <b>T.</b> Last <b>LAUX</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Female</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>3/10/1910</b>	9. AGE (last birthday) <b>50</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Oran, Missouri.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Emil Stubenrach</b>		13b. MOTHER'S MAIDEN NAME <b>Bertha Metz</b>		14. NAME OF HUSBAND OR WIFE <b>Joseph Laux</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Nil.</b>	17. INFORMANT <b>Joseph Laux, Auxvasse, Mo.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>INTRACEREBRAL HEMORRHAGE, ETIOLOGY UNDETERMINED</b>		<b>16 DAYS</b>
DUE TO (b)		
DUE TO (c)		<b>331x</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>QUESTIONABLE ANEURYSM OF LEFT INTERNAL CAROTID ARTERY</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 <b>5:00</b> a.m. p.m.	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 <b>AUGUST 7, 1960</b> to <b>AUGUST 21, 1960</b> and last saw her alive on <b>AUGUST 21, 1960</b>		Death occurred at <b>5:00 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <i>C. J. Vermillion, M.D.</i>	(Degree or title) <b>M. D.</b>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>8/22/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-22-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Gardens Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Columbia, Missouri.</b>

24. FUNERAL DIRECTOR <b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 23 1960</b>	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

EMERALD STATE COLLEGE

REC 13 1907

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Harvey Kable  
Licensed Embalmer No. 4596  
P. O. Address St Louis, Mo

EMERALD STATE COLLEGE

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.