

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 16 1960

317

Primary Registration District No. 545

Registrar's No. 3466

60-048215
STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY St. Louis				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 Maplewood		Length of stay in 1b 11 Days		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Maplewood Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6739 Arthur Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First JUNE Middle M. Last LAUFER				4. DATE OF DEATH Month Nov. Day 27 Year 1960									
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Dec. 17, 1886		9. AGE (last birthday) 73		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Illinois			12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME Charles Vaughn				13b. MOTHER'S MAIDEN NAME Hanna Cosgrove				14. NAME OF HUSBAND OR WIFE Late Louis P. Laufer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 495-32-3276		17. INFORMANT Address Maxine Holloran 7610 Flora (17)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Hemiparesis & aphasia = c coma										INTERVAL BETWEEN ONSET AND DEATH 6 weeks			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Vasculat. Disease										10 yrs			
DUE TO (c) Generalized arteriosclerosis													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Malnutrition & Avitaminosis								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					
19. WAS AUTOPSY PERFORMED? 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 Hour 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 10-23-60 to 11-27-60 and last saw her ^{her} _{him} live on 11-16-60 Death occurred at 10:20 P. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Grant Lyubman M.D.				22b. ADDRESS 7961 Big Bend Webster				22c. DATE SIGNED 11-28-60					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Rail)		23b. DATE Nov. 30, 1960		23c. NAME OF CEMETERY OR CREMATORY LOCAL				23d. LOCATION (City, town, or county) Litchfield, Ill.					
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.				25. DATE RECD. BY LOCAL REG. 11-29-60		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William O. White

Licensed Embalmer No. 423

P. O. Address 4228 1/2 St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.