ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-030889
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7430

FILED AUG 18 1961

DATE AMENDED 7-

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: 1 yr.
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b: 8 mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Chronic Hosp. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY:
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4898 Lee Ave. — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Grace Middle: H. Last: Lauer

4. DATE OF DEATH Month: 8 Day: 8 Year: 61

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8-13-90

9. AGE (last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BOX CLOSER RET.

10b. KIND OF BUSINESS OR INDUSTRY: PAPER BOX MFR.

11. BIRTHPLACE (City and state or country): ST. L. Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: George Lauer

13b. MOTHER'S MAIDEN NAME: Amelia Vanator

14. NAME OF HUSBAND OR WIFE: — —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

17. INFORMANT Address: MR. EARL LAUER 4896 LEE AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 493 X
INTERVAL BETWEEN ONSET AND DEATH:
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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 ☐ NOT WHILE AT WORK ☐

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 12-16-59, to 8-8-61 and last saw her/him alive on 8-8-61
Death occurred at 5:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): MD

22b. ADDRESS: 5600 Arsenal St

22c. DATE SIGNED: 8/10/61

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: 8/10/61

23c. NAME OF CEMETERY OR CREMATORY: NEW ST. MARCUS CEM.

23d. LOCATION (City, town, or county) (State): ST. LOUIS CO. MO.

24. FUNERAL DIRECTOR: DREHMANN-HARRAL ADDRESS: 1905 UNION

25. DATE RECD. BY LOCAL REG.: AUG 10 1961

26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

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 Warren A Carver

Licensed Embalmer No. 3534

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.