

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046549

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12341** STATE FILE NUMBER

FILED JAN 11 1962

DATE AMENDED

INSTEAD OF

DOCUMENT

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 72 yrs. | 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 Lutheran Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 3509a Pennsylvania Ave. Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First SOPHIA Middle Last LAUGHNEY | | | 4. DATE OF DEATH Month December Day 28, Year 1961 | |
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|-------------------------|----------------------------------|---|--------------------------------------|--|--------------------------------|------------------------------|
| 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 8/12/1890 | 9. AGE (last birthday) 72 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY At home | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | 12. CITIZEN OF WHAT COUNTRY USA |
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| 13a. FATHER'S NAME Henry Noll | 13b. MOTHER'S MAIDEN NAME Marie Seele | 14. NAME OF HUSBAND OR WIFE John Laughney |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 17. INFORMANT Mr. Donald E. Laughney, 3509a Pennsylvania |
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| 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) Cerebral Vascular Accident | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Atherosclerosis. | |
| | DUE TO (c) 331x | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) | | 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.) |
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| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year |
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| 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 |
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>Robert E. Smith</i> (Degree or title) | 22b. ADDRESS 1300 Clark | 22c. DATE SIGNED 1-2-62 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE Jan. 2, 1962 | 23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri |
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| 24. FUNERAL DIRECTOR Beiderwieden F. H. Inc., 1936 St. Louis | 25. DATE RECD. BY LOCAL REG. JAN 2 1962 | 26. REGISTRAR'S SIGNATURE <i>Lead Smith, M.D.</i> |
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ITEM NO. SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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 Homer W. Fritz

Licensed Embalmer No. 3882

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.