

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-006043  
STATE FILE NUMBER

Registration District No. 100 Primary Registration District No. \_\_\_\_\_ Registrar's No. 18

**FILED FEB 19 1962**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Dent</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Salem</b>	a. STATE <b>Missouri</b>	b. COUNTY <b>Dent</b>
Length of stay in 1b <b>4 yrs</b>		c. CITY OR TOWN <b>Salem</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jone Nursing Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>603 So Grand</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>Louis</b>	Middle <b>Lauritzen</b>	Last	4. DATE OF DEATH	Month <b>Feb</b>	Day <b>13</b>	Year <b>1962</b>
-------------------------------------	-----------------------	----------------------------	------	------------------	---------------------	------------------	---------------------

5. SEX <b>male</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>3-2-62</b>	9. AGE (last birthday) <b>99</b>	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) <b>farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>x</b>	11. BIRTHPLACE (City and state or country) <b>Denmark</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
--	---	--	---

13a. FATHER'S NAME <b>Chris Lauritzen</b>	13b. MOTHER'S MAIDEN NAME <b>Hilda Lauritzen</b>	14. NAME OF HUSBAND OR WIFE <b>Emily Rathke</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>x</b>	17. INFORMANT <b>Mrs John McNeill</b>	Address <b>Salem 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>Chronic myocarditis</b>	<b>2 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>generalized arteriosclerosis</b>	<b>?</b>
	DUE TO (c) <b>senility</b>	

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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

19. WAS AUTOPSY PERFORMED? YES <input 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 _____ 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 <b>Salem</b>	COUNTY <b>Dent</b>	STATE <b>MO</b>
--	--	--	-----------------------	--------------------

21. I attended the deceased from approx 1945 to 2-13-62 and last saw her alive on 2-10-62  
Death occurred at 3 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. D. ...</i>	(Degree or title) <b>DO.</b>	22b. ADDRESS <b>Salem, Mo.</b>	22c. DATE SIGNED <b>2-15-62</b>
------------------------------------	---------------------------------	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>2-15-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Grove Cem</b>	23d. LOCATION (City, town, or county) (State) <b>Salem Missouri</b>
--	-----------------------------	--	--

24. FUNERAL DIRECTOR <b>Spencer Funeral Home Inc</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>2/15/62</b>	26. REGISTRAR'S SIGNATURE <i>M. M. ...</i>
---	---------	--	---

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

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 \_\_\_\_\_  
 Licensed Embalmer No. 9370  
 P. O. Address \_\_\_\_\_

**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 \_\_\_\_\_  
 Licensed Embalmer No. 9370  
 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.