

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-021408

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1501

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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24000

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAY 28 1962		1. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
2. I. PLACE OF DEATH		a. STATE <u>Mo</u> b. COUNTY <u>ST. Louis</u>	
a. COUNTY <u>ST. Louis</u>		c. CITY OR TOWN <u>AFFTON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>AFFTON</u>		Length of stay in 1b <u>YRS.</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>9273 FORMAN Rd.</u>		d. STREET ADDRESS (If outside, give location) <u>9273 FORMAN Rd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <u>Nicholas</u> Middle <u>P.</u> Last <u>LAFFLER</u>		Month <u>MAY</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice President FREIGHT WAYS INC.</u>		11. BIRTHPLACE (City and state or country) <u>ST. Louis Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>JOSEPH LAFFLER</u>		14. NAME OF HUSBAND OR WIFE <u>OLGA LAFFLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		17. INFORMANT Address <u>1 OLGA LAFFLER 9273 FORMAN Rd.</u>	
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) <u>HEART DISEASE</u>			<u>UNKNOWN</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b) <u>UNDETERMINED ETIOLOGY</u>			
DUE TO (c) _____			
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 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 <u>APRIL 25, 1958</u> to <u>MAY 17, 1962</u> and last saw ^{her} him alive on <u>MAY 7, 1962</u>			
Death occurred at <u>8:15 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>950 Francis Place Clayton 5 Mo</u>	22c. DATE SIGNED <u>5-17-62</u>
23a. BURIAL, CREMATION, or MOVEMENT (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>MAY 21, 1962</u>	<u>OUR REDEEMER</u>	<u>ST LOUIS Co. MO</u>
24. FUNERAL DIRECTOR	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE	
<u>Thomas Rutis 2906 Morris</u>	<u>5-17-62</u>	<u>John C. Murphy Md.</u>	

Dr. J. J. J. J.
950 Francis St.

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 *Eleanor Province*

Licensed Embalmer No. *3403*

P. O. Address *2906 Grover*

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.