

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036404

DO NOT WRITE ON THIS STUB

AMENDED

Registered District No. **318** Primary Registration District No. **1003** Registrar's No. **0418** STATE FILE NUMBER

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b>		a. STATE <b>Mo</b>	b. COUNTY
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)		d. STREET ADDRESS <b>2344 ARKANSAS</b>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
First <b>JACOB</b> Middle <b>LAUB</b> Last		4. DATE OF DEATH Month <b>OCT. 1,</b> Day <b>1962</b> Year	
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>2-2-1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED DAY LABORER</b>		9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>ROUMANIA</b>	IF UNDER 24 HR Hours Min.
12. CITIZEN OF WHAT COUNTRY <b>ROUMANIA</b>		13a. FATHER'S NAME <b>JACOB LAUB</b>	14. NAME OF HUSBAND OR WIFE <b>KATHARINA LAUB</b>
13b. MOTHER'S MAIDEN NAME <b>KATHERINE WELTER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not of unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>
17. INFORMANT <b>KATHARINA LAUB</b>		Address <b>2344 ARKANSAS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>obstruction of trachea by mucus</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)			
DUE TO (c)			<b>922-9-46</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 checked="" 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	COUNTY STATE
21. I attended the deceased from <b>9/19/62</b> to <b>10/1/62</b> and last saw her/him alive on <b>10/1/62</b>		Death occurred at <b>3120 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>E P Schultz M.D.</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE</b>	22c. DATE SIGNED <b>10/1/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>OCT 3, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEM.</b>	23d. LOCATION (City, town, or county) <b>ST. LOUIS CO Mo.</b>
24. FUNERAL DIRECTOR <b>Thomas Katis 2906 Gravois</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>OCT 2 1962</b>	26. REGISTRAR'S SIGNATURE <b>Boyd Smith, M.D.</b>

SCHULTZ

**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

*J. G. Humphrey*

Licensed Embalmer No. 4772

P. O. Address

290 E. Lincoln

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.