

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-019329
STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 257

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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| FILED MAY 20 1963 | |
| <p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>CAPE</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAPE GIRARDEAU</u> Length of stay in 1b <u>2 DAYS</u></p> <p>c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SOUTHEAST MISSOURI HOSP</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> | <p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u></p> <p>c. CITY OR TOWN <u>BENTON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> |
| <p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>JAKE</u> Middle <u>(NMN)</u> Last <u>LAUB</u></p> <p>4. DATE OF DEATH Month <u>APRIL</u> Day <u>9</u> Year <u>1963</u></p> | <p>5. SEX <u>MALE</u></p> <p>6. COLOR OR RACE <u>WHITE</u></p> <p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>AUG 3 1892</u></p> <p>9. AGE (last birthday) <u>70</u> IF UNDER 1 YEAR Months <u>8</u> Days <u>6</u> IF UNDER 24 HR Hours _____ Min. _____</p> |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTODIAN (RET.)</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>SCOTT CO. COURTHOUSE</u></p> <p>11. BIRTHPLACE (City and state or country) <u>JACKSON COUNTY, ILL.</u></p> <p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p> | <p>13a. FATHER'S NAME <u>WILLIAM LAUB</u></p> <p>13b. MOTHER'S MAIDEN NAME <u>MINNIE HOFFMAN</u></p> <p>13c. NAME OF HUSBAND OR WIFE <u>VIRGINIA IRENE LAUB</u></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u></p> <p>16. SOCIAL SECURITY NO. _____</p> <p>17. INFORMANT Address <u>61 MRS. JAKE LAUB - BENTON, MISSOURI</u></p> |
| <p>18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Shock</u></p> <p style="text-align: center;">DUE TO (b) <u>infarction of ilium</u></p> <p style="text-align: center;">DUE TO (c) _____</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> | |
| <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease indicated in PART I. <u>Bilateral bronchiopneumonia, pulmonary emphysema, bronchiectasis</u></p> <p>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</p> | |
| <p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____</p> <p>20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m.</p> | <p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p> <p>20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____</p> |
| <p>21. I attended the deceased from <u>march, 1960</u> to <u>death</u> and last saw <u>him</u> alive on <u>April 9, 1963</u></p> <p>Death occurred at <u>6:20 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p> | |
| <p>22a. SIGNATURE (Degree or title) <u>Jean A. Chapman, M.D.</u></p> <p>22b. ADDRESS <u>402 Broadway Cape Girardeau, Mo. 65608</u></p> <p>22c. DATE SIGNED <u>15 May 63</u></p> | <p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p> <p>23b. DATE <u>APRIL 12, 1963</u></p> <p>23c. NAME OF CEMETERY OR CREMATORY <u>FORREST HILLS MEM. CEM. (NEAR)</u></p> <p>23d. LOCATION (City, town, or county) (State) <u>MORBEY MISSOURI</u></p> |
| <p>24. FUNERAL DIRECTOR <u>BISPLINGHOFF FUNERAL HOME - CHAFFEE, Mo.</u> ADDRESS _____</p> <p>25. DATE RECD. BY LOCAL REG. <u>5-17-1963</u></p> <p>26. REGISTRAR'S SIGNATURE <u>Jane Kasten</u></p> | |

USE BLACK INK OR TYPEWRITER RIBBON

MAY 22 1963

MAY 21 1963

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 Jack T. Burnett

Licensed Embalmer No. 4473

P. O. Address Chaffee, Missouri

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.