

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED JAN 30 1948

Registration District No. 47

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3008

State File No.

412

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Callaway  
(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital No. 1. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 years  
(Specify whether years, months or days)  
In this community same

3. (a) PRINT FULL NAME LAURA E. LAUGHLIN

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W. 6. (a) Single, widowed, married, divorced M.

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 4 18 1870  
(Month) (Day) (Year)

8. AGE: Years 77 Months 9 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name D.K. 9

13. Birthplace D.K. (City, town, or county) (State or foreign country)

14. Maiden name D.K. (City, town, or county) (State or foreign country)

15. Birthplace D.K. (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Fulton Mo.

17. (a) Removal (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation California Dps.

18. (a) Signature of funeral director William J. Schumacher

(b) Address California

19. (a) Jan-1948 (b) Registrar's signature Joie Morink

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Moniteau  
(c) City or town California  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 18 year 1948 hour 10 minute 9 A. M.

21. I hereby certify that I attended the deceased from 1-15/48 to 1-18/48 that I last saw him alive on 1-18/48 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia  
1. pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature B. P. Price (M.D. or other)

Address Fulton Mo. Date signed 1/18/48

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Date Filed JAN 29 1948

District File Number                     

District Health Officer No. 9

RECEIVED

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### 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.....

....., Registered Apprentice No.....,  
working under my personal supervision.

Signed.....

*HC Friedman*

Licensed Embalmer No.....

*2854*

P. O. Address.....

*California Mo*

**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 this body is not embalmed, fact should be so stated above.