

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31678

FILED SEP 21 1951

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7646

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MO</u> b. COUNTY <u>St. Louis</u>	
b. CITY OR TOWN <u>St. Louis</u>	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <u>St. Louis County, 4310</u>	d. STREET ADDRESS (If rural, give location) <u>6220 Wagner</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis State Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>MELLA</u> b. (Middle) <u>McMAHON</u> c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>August 27-51</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow 2</u>	8. DATE OF BIRTH <u>4-25-1870</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Winchester 2111</u>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <u>John M. Laughlin</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Simon</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Agnes Coban</u>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1947x</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <u>H200</u>
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22. I hereby certify that I attended the deceased from May 5, 1947, to Aug. 27, 1951, that I last saw the deceased alive on Aug. 27, 1951 and that death occurred at 5:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE <u>John Schlenker M.D.</u> (Degree or title)	23b. ADDRESS <u>5400 Arsenal Street</u>	23c. DATE SIGNED <u>8/28/51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>11</u>	24b. DATE <u>8-29-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County, MO</u>
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DATE REC'D. BY LOCAL REG. <u>AUG 28</u>	REGISTRAR'S SIGNATURE <u>Glenn Smith M.D. R.P.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W.C. Hartmann</u> ADDRESS <u>Overland</u>
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Al C Ortman

Signed.....
Student Embalmer

Licensed Embalmer No. *2478*

P. O. Address *Oberland N*

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.