

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County St. Louis
Township Central
or
Village _____
or
City Webster Grove (NO. _____ St. _____ Ward _____)

Registration District No. 788 File No. 426011
Primary Registration District No. 4471 Registered No. 79

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James Peter Lapping

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF DEATH December 19, 1911
(Month) (Day) (Year)

DATE OF BIRTH Oct. 14, 1874
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 20, 1911, to Dec. 19, 1911, that I last saw him alive on Nov. 28, 1911, and that death occurred, on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:

AGE 37 yrs. 2 mos. 5 ds. IF LESS than 1 day, ____ hrs. ____ min.?

23A
106B
Pulmonary Tuberculosis
(Duration) ____ yrs. ____ mos. ____ ds.

OCCUPATION (a) Trade, profession, or particular kind of work Gardener
(b) General nature of industry, business, or establishment in which employed (or employer) 1-03

BIRTHPLACE (City or town, State or foreign country) St. Louis County

Contributory Bronchial Catarrh
(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

NAME OF FATHER James Lapping

BIRTHPLACE OF FATHER (City or town, State or foreign country) Glasgow, Scotland

MAIDEN NAME OF MOTHER Mary A. Kelly

BIRTHPLACE OF MOTHER (City or town, State or foreign country) County Kildare, Ireland

(Signed) W. H. Harrison M.D.
Dec 28, 1911 (Address) 3574 Locust St. St. Louis, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

(Informant) Margaret Lapping

(ADDRESS) 467 Edgar, Webster Grove, Mo.

PLACE OF BURIAL OR REMOVAL St. Peter DATE OF BURIAL Dec 21, 1911

Filed 12/21, 1911 REGISTRAR

UNDERTAKER Parker & Co Webster Grove

REPRODUCED FROM ORIGINAL RECORDS, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

HUGH STEPHENS, JEFFERSON CITY.



REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County St. Louis Registration District No. 785 File No. _____
Township _____ or Village Webster Grove Primary Registration District No. 4471 Registered No. 79
City _____ (NO. _____) St. _____ Ward _____
[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James Peter Lapping

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>S</u> (Write the word)
DATE OF BIRTH <u>Oct 14</u> , 18 <u>74</u> (Month) (Day) (Year)		
AGE <u>37</u> yrs. <u>2</u> mos. <u>5</u> ds. If LESS than 1 day, hrs. or min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Gardener</u> (b) General nature of industry, business, or establishment in which employed (or employer)		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 19, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 20, 1911, to Dec 19, 1911, that I last saw him alive on Nov 28, 1911, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

PARENTS

BIRTHPLACE (City or town, State or foreign country)
St. Louis, Mo.

NAME OF FATHER
James Lapping

BIRTHPLACE OF FATHER (City or town, State or foreign country)
Glasgow Scotland

MAIDEN NAME OF MOTHER
Margie Kelly

BIRTHPLACE OF MOTHER (City or town, State or foreign country)
Cork Ireland

Contributory (SECONDARY) Bronchial catarrh
(Duration) yrs. 5 mos. _____ ds.

(Signed) John Harrison M. D.
(Address) St. Louis, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. _____ mos. _____ ds. In the State yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?
Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margaret Lapping
(ADDRESS) 40 Edgar Webster Grove

Filed 12/7 1911 REGISTRAR H. H. Polding

PLACE OF BURIAL OR REMOVAL St. Kellers DATE OF BURIAL Dec 21, 1911

UNDERAKER Parker & Co ADDRESS Webster Grove

Revised United States Standard Certificate of Death

[[Approved by U. S. Census and American Public Health
Association]]

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