N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. 31119

or

Village ..... Primary Registration District No. 100 Registered No. 8430

or

City St. Louis (NO Mullanphy Hospital St. N Ward)

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

2 FULL NAME Charles A Harper

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Nov. (Month) 24 (Day), 1880 (Year)

7 AGE: 67 yrs. 9 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Superintendent of Riddle Bro. Cassus Co
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country): Lexington Ky

PARENTS

10 NAME OF FATHER: James A. Harper

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Dover, Delaware

12 MAIDEN NAME OF MOTHER: Mary E. Bishop

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Lexington Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James A Harper

(Address) 4843 Labadie av

15 Filed SEP -7 1918, 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 5 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 25, 1918, to Sept 5, 1918, that I last saw him alive on Sept 5, 1918, and that death occurred, on the date stated above, at 6 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

41B 40

(Duration) X yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Guy Simpson M. D.

Sept 6, 1918 (Address) 4701 St Louis

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. 4 ds. In the State 45 yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? 4843 Labadie ave

Former or usual residence 4843 Labadie ave

19 PLACE OF BURIAL OR REMOVAL: Valhalla cemetery

DATE OF BURIAL: Sept 7, 1918

20 UNDERTAKER: Cullinane Bros

ADDRESS: 1710 N Grand av

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

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

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE
.....yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day) ....., 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....
that I last saw h.....alive on ....., 191.....,
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.