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

Do not use this space.

3449

**1. PLACE OF DEATH**

County ..... Registration District No. 791 File No. 1085

Township ..... Primary Registration District No. 1003 Registered No. 1085

City St. Louis, Mo. (No. Barnes Hospital ..... St. ..... Ward)

**2. FULL NAME** Almos Samuel Harper

(a) Residence. No. Success, Arkansas St., 12 Ward. Success, Ark.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Susie Harper

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov. 8 1882

7. AGE: Years 42 | Months 2 | Days 20 | If LESS than 1 day, ..... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): Maynard
(STATE OR COUNTRY): Ark.

PARENTS

10. NAME OF FATHER: Wm. H. Harper
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Ill.
12. MAIDEN NAME OF MOTHER: Unknown Kerley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Tenn.

14. INFORMANT: Mrs. L. M. Ferguson
(Address): 8550 Church Rd.

15. FILED JAN 31 1927 19 Max C. Starkoff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR): 1-28-1927

17. I HEREBY CERTIFY, That I attended deceased from 1-21, 1927, to 1-28, 1927 that I last saw h. 1 M. alive on 3.45 P.M. 1-28, 1927, and that death occurred, on the date stated above, at 3.45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
46D Cerebral Hemorrhage
Apoplexy
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Carcinoma of the Rectum
..... (duration) ..... yrs. ..... mos. ..... ds.

45

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? yes DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. M. McCaughan, M. D
1-28, 1927 (Address) Barnes Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Corning, Ark.
DATE OF BURIAL: 1-31 1927

20. UNDERTAKER: Peetz Bros
ADDRESS: 3029 Lafayette

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.

... INKMYTHIS IS A PERMANENT RECORD

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No. 791 File No.....

Township..... Primary Registration District No. 1003 Registered No. 1085

City St. Louis Mo (No....., ..... St. ..... Ward)

**2. FULL NAME** Almos Samuel Harper

(a) Residence. No..... St., ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 8, 1882

7. AGE

| Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|
| 44 | 2 | 20 | |

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED ....., 19.. Max C Starkloff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 28, 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

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

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Corning, Ark
DATE OF BURIAL: 1-30 1927

20. UNDERTAKER: Peetz Bros 3029
ADDRESS: Lafayette

SUPPLEMENTARY

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

N... y item of information sho... ...plied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so ... properly classified. Exact statement of OCCUPATION is very important.

S-3449