

MAY 15 1940 791  
Registration District No. **791**Primary Registration District No. **1003**

## 1. PLACE OF DEATH:

(a) County St Louis, Mo  
 (b) City or town St Louis, Mo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: BARNES HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 days  
 (Specify whether  
 In this community  
 years, months or days)

3. (a) PRINT FULL NAME Laura Jane Topping 15 2  
 3. (b) If veteran, name war none  
 3. (c) Social Security No. none

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Henry V. Topping 6. (c) Age of husband or wife if alive years

7. Birth date of deceased June 27th 1850  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
89 10 0 hr. min.

9. Birthplace New Castle Pa.  
 (City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business

MOTHER FATHER { 12. Name William H. Christie.

13. Birthplace unknown Pa.  
 (City, town, or county) (State or foreign country)

14. Maiden name Elizabeth (unknown)

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

16. (a) Informant's own signature Elizabeth Topping.

(b) Address 4964 Parkview, Pl.

17. (a) Burial (b) Date thereof 4 / 29 / 40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director C. R. Lupton & Sons.

(b) Address 7233 Delmar, Blvd.

19. (a) APR 29 1940 (b) J. B. Bueck  
 (Date received local registration) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County \_\_\_\_\_  
 (c) City or town St Louis 12  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 4964 PARKVIEW PLACE  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27  
 year 1940 hour 2<sup>45</sup> minute 0 M.

21. I hereby certify that I attended the deceased from April 21, 1940, to April 27, 1940;  
 that I last saw her alive on April 27, 1940,  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Embolism - cerebral

Due to Fibrillation

Due to ? Arteriosclerosis of Coronary Vessels - ? Occlusion

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

Major findings: \_\_\_\_\_

Of operations 3/4

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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? 44

(e) Means of injury \_\_\_\_\_  
 (Specify type of place)

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

23. Signature Russell H. D. (M. D. or other) \_\_\_\_\_

Address BARNES HOSPITAL Date signed \_\_\_\_\_

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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 Bradford A. Miles

Licensed Embalmer No. 2901

P. O. Address St Louis 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, above space should be left blank.**