

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29732

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 7492

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Admitted 7/8/40
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 116 No. 13th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Vasker S. Stapleton 314

3. (b) If veteran, name war World War 3. (c) Social Security No. Unavailab

4. Sex male 5. Color or race negro 6. (a) Single, widowed, married, divorced widower

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 1 1892
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>11</u>	<u>3</u>	hr. _____ min. _____

9. Birthplace Howard Co., Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name Sid (Surname unknown)

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

14. Maiden name Helen (Surname unknown)

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

16. (a) Informant M. Schilling

(b) Address Clinical Clerk, VAF, Jeff. Bks., Mo.

17. (a) Removal Burial (b) Date thereof 8/6/40
(Burial, cremation, or removal) (Month) (Day) (Year)
NAT. CEM.

(c) Place: burial or cremation Springfield, Illinois

18. (a) Signature of funeral director Charles J. Kater

(b) Address 4107 Finney Avenue

19. (a) AUG 6 - 1940 (b) H. R. Meyer
(Date received locally) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4th
ed. year 1940 hour 12:50 A.M. minute --- a.m.

21. I hereby certify that I attended the deceased from July 8, 1940, 19____, to August 4, 1940

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death
Syphilitic disease of heart with cardiac enlargement, myocardial damage, aortic insufficiency, myocardial insufficiency. Duration unkn.

Due to _____
Due to _____
Other conditions none. (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy No 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) no
(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? _____

(Specify type of place)
While at work? Harry Levine (e) Means of injury Mr GKA
23. Signature HARRY LEVINE, M.D. (M. D. or other)
Address Actg. Ch. Med. Officer Date signed 8/5/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

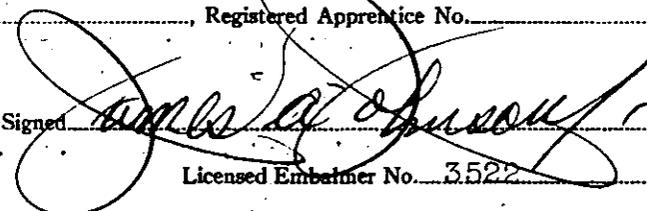
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

James A. Johnson

Registered Apprentice No.

working under my personal supervision.

Signed



Licensed Embalmer No. 3522

P. O. Address 4107 Finney Avenue

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.