

FILED JAN 31 1945
318

Primary Registration District No.

1003

Registrar's No.

620

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:
De Paul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5655 Lotus Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINTED FULL NAME Michael Llyod Leaphart

(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex m 5. Color or race w. 6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 6 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 14 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Llyod Leaphart
13. Birthplace South Carolina
(State or foreign country) {
14. Maiden name Frances Furlong
15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Frank J. Furlong
(b) Address 5655 Lotus Ave.

17. (a) Burial (b) Date thereof 1-22-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Cabvary

18. (a) Signature of funeral director Sullivan Funeral Di
(b) Address 2849 No. Euclid Ave.

19. (a) JAN 22 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. 20th day
1945 year 7 hour 10 minute 10 P.M.

21. I hereby certify that I attended the deceased from Jan 6, 1945, to Jan 20, 1945
that I last saw him alive on Jan 20, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death diarrhea
Due to _____
Due to 119 a
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

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?
(Specify type of place) _____

23. Signature W. W. ... (M. D. or other) _____
Address 2803 N. Kingshighway Date signed 1-22-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Robert L. Pinkman

Licensed Embalmer No. 3553

P. O. Address.....

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, fact should be so stated above.