

STATE BOARD OF HEALTH OF MISSOURI.
STANDARD CERTIFICATE OF DEATH

State File No. 18949

FILED JUN 14 1945

Primary Registration District No. 1003

Registrar's No. 5421

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: St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County St. Francois

(c) City or town St. Francois River
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? / (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William LaPlant

3. (b) If veteran, name war World War # 1

3. (c) Social Security No. Unknown

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

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

7. Birth date of deceased: January 9 1880
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>5</u>	<u>11</u>	hr. min.

9. Birthplace Ste. Genevieve County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Louis LaPlante

13. Birthplace Ste. Genevieve County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Cornelia Labryere

15. Birthplace Ste. Genevieve County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Clovis G. LaPlante

(b) Address St. Francois, Missouri

17. (a) Burial (b) Date thereof 6-24-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flat River, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd

19. (a) JUN 21 1945 (b) J. T. Bradeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20th
year 1945 hour 9:30 minute P. M.

21. I hereby certify that I attended the deceased from 6/12/45
19. to 6/20/45 19. ;
that I last saw him alive on 6/20/45 19. ;
and that death occurred on the date and hour stated above.

Immediate cause of death: Sub Arachnoid hemorrhage

Due to _____

Due to _____

Other conditions: Generalized Arterio Sclerosis
Late Latent Syphilis
(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? _____

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Carroll Hendrix (M. D. or other)
Address 1515 Lafayette Date signed 6/21/45

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

Albert L. Happe

Licensed Embalmer No. 2971

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.