

#46438
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 6 1945
Registration District No. **318**

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29075**
Registrar's No. **8417**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....
(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-Max C. Starkloff
(If not in hospital or institution, write street number or location) **Memorial**
(d) Length of stay: In hospital or institution **4 days** (Specify whether
In this community **10 Years** (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **17 B**
(d) Street No. **1427 Dolman** (If rural, give location) **9**
(e) Citizen of foreign country? **No** (Yes or No) **0**
If yes, name country

3. (a) PRINT FULL NAME **LEVI HARPER**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

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

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

7. Birth date of deceased **Nov 27 1883**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 10 1 hr. min.

9. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **LABORER**

11. Industry or business

12. Name **Dale Harper**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Carl F Harper**

(b) Address **1812 Texas**

17. (a) **Burial** (b) Date thereof **10 / 1 / 45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Matthews**

18. (a) Signature of funeral director **A. W. McLaughlin**

(b) Address **2301 Lafayette Ave**

19. (a) **SEP 28 1945** (b) **J. H. ...**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **28th**
year **1945** hour **5:47** minute **A** M.

21. I hereby certify that I attended the deceased from **9/24/45**
to **9/28/45**, 19____, to **9/28/45**, 19____;
that I last saw him alive on **9/28/45**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebrovascular accident, hemorrhage**

Due to _____

Due to _____

Other conditions **Alcoholism**
(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) (Means of injury)

23. Signature **R. L. Stubblefield** (M. D. or other) _____

Address **1420 Nathan** Date signed **9-28-45**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

00
17
9

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.....

L. R. Cooper

Licensed Embalmer No.....

3633

P. O. Address.....

2317 Lafayette

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.