

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAY 7 1948**

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1000  
Registrar's No. 934

Registration District No. 5176 Primary Registration District No. 6076

1. PLACE OF DEATH:  
(a) County St. Louis  
(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 Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Since 12/22/1940  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis 080  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6426 Virginia Ave. 9  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LeCOMPTÉ, Julian B.  
(b) If veteran, name war World I  
(c) Social Security No. None

4. Sex Male 0 5. Color or race White  
6. (a) Single, widowed, married, divorced Single 0  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 14 1898  
(Month); (Day) (Year)

8. AGE: Years 47 Months 9 Days 11 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Springfield, Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Soda Dispenser

11. Industry or business \_\_\_\_\_  
12. Name John H. LeCompte  
13. Birthplace Missouri 0  
(City, town, or county) (State or foreign country)  
14. Maiden name Katherine Stagg  
15. Birthplace Missouri 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Clinical Clerk, Vet. Adm. Hosp.  
(b) Address Jefferson Barracks, Missouri  
17. (a) Burial (b) Date thereof April 29-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation National Cemetery  
18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.  
(b) Address 7814 S. Broadway St. Louis, Mo.  
19. (a) 4-27-46 (b) E. M. Garon M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 25  
year 1946 hour 4:00 minute A M.

21. I hereby certify that I attended the deceased from 12/22/40 19\_\_\_\_ to 4/25/46 19\_\_\_\_  
that I last saw him alive on April 25 19 46  
and that death occurred on the date and hour stated above.

Immediate cause of death ENCEPHALITIS LETHARGICA Duration UNK.

Due to 37c  
Due to \_\_\_\_\_

Other conditions BRONCHO PNEUMONIA  
(Include pregnancy within 3 months of death)

Major findings: Of operations No Operation  
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?

While at work \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_  
23. Signature E. E. Stillwell, M.D. (M. D. or other) 0  
Address Vet. Adm. Hosp. Jeff. Brks., Mo. Date signed 4/25/46

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

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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 *L. C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address. *7814 S. Broadway*

**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.**