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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED DEC 4 30 1946**  
Registration District No. 219

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**  
Primary Registration District No. 1002

**38670**  
State File No. \_\_\_\_\_  
Registrar's No. 10236

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

**1. PLACE OF DEATH:**  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(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)  
(d) Length of stay: In hospital or institution. 30 days  
In this community 5 years  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME LAWRENCE HARKINS  
3. (b) If veteran, name war nil 3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced D  
6. (b) Name of husband or wife Flora 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased August 25, 1882  
(Month) (Day) (Year)

8. AGE: Years 64 Months 3 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Louisville, Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation carpenter

11. Industry or business retired

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant Thomas Harkins

(b) Address 1806 Ohio Avenue

17. (a) burial (b) Date thereof 11-29-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address 2301 Lafayette Av. St. Louis, Mo.

19. (a) NOV 30 1946 (Date received local registrar)  
J. Z. Brudeck (Registrar's signature)

**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. 1806 Ohio Avenue  
Memorial (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov. day 26th  
year 1946 hour 10:08 minute 8 M.

21. I hereby certify that I attended the deceased from 11/9/46  
to 11/26/46  
that I last saw h. im alive on 11/26/46  
and that death occurred on the date and hour stated above.

Immediate cause of death Encephalitis, left chest due to meningitis  
Duration 2 1/2 weeks

Due to Fusiform bacilli, pneumococci, Staphylococcus non-hemolytic strep  
Due to Fusiform

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy Denied

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) \_\_\_\_\_

(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? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Albert J. Sweet 11/26/46 (other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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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..... *R W Cooper*.....  
Licensed Embalmer No. *38630*.....  
P. O. Address *2301 Lafayette Ave*.....

**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.**