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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUN 28 1948
Registration District No. **318**

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

21005
State File No. _____
Registrar's No. **5596**

Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Park Lane Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Herman John Jaspering
3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Widower 2
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased November 6 1866
(Month) (Day) (Year)

8. AGE: Years 81 Months 7 Days 14
If less than one day hr. _____ min. _____

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

10. Usual occupation Retired Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown 9
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edna Hoskins
(b) Address Foristell, Mo.

17. (a) Burial (b) Date thereof 6-22-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wright City, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) JUN 21 1948 J. F. Bredack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Warren 109
(c) City or town Foristell
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) _____
(e) Citizen of foreign country? NR (Yes or No) _____
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20
year 1948 hour 5 minute 15 AM.

21. I hereby certify that I attended the deceased from June 18,
1948 to June 20, 19 48
that I last saw him alive on June 20, 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Banner's Disease
involving the right leg,
thigh, knee and including the
middle third of the leg.
Due to Complete Necrosis of same.
Disease Myocarditis, Chronic

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

Duration _____
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? _____

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature [Signature] (M. D. or other) M. D.
Address 4930 Lindell Blvd. Date signed 6/21/48

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. Wilkerson*
Licensed Embalmer No. 3575
P. O. Address *St. Louis Mo*

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.