

MISSOURI DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 21222  
Registrar's No. 5503

FILED JUN 28 1948 318  
Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: DePaul Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1-week  
In this community 20 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis  
96  
(c) City or town Chesterfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. Woods Mill & Conway Rds.  
N.R. (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lawrence M. Persons

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

4. Sex O M. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.  
6. (b) Name of husband or wife Elisabeth Persons 6. (c) Age of husband or wife if alive 26 years  
7. Birth date of deceased Jan. 15th., 1896  
(Month) (Day) (Year)

8. AGE: Years 52 Months 5 Days 1 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Quincy Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation Engineer McQuay Norris

11. Industry or business \_\_\_\_\_

12. Name William Persons

13. Birthplace Ill.

14. Maiden name Margaret Marston

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

16. (a) Informant Mrs. Elisabeth Persons

(b) Address Chesterfield, Mo.

17. (a) Burial (b) Date thereof 6-19-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly  
(b) Address 3840 Lindell Blvd.

19. (a) JUN 17 1948 (b) J. F. Brecken  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16th.,  
year 1948 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from 6-11, 1948 to 6-16, 1948  
that I last saw him alive on 6-16, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion sde  
arterio-sclerosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

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) (e) Means of injury \_\_\_\_\_  
23. Signature J. D. Casper (M. D. or other) M.D.  
Address 4952 Maryland Date signed 6-17-48

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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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 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.**