

Registration District No. 318

Primary Registration District No. 1003

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: his residence
Pronounced dead at City Hospital 3
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County oas
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17
(d) Street No. 5636 Lissette
2 (If rural, give location) 9
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country.....

3. (a) PRINT FULL NAME Cornelius Lepere
3. (b) If veteran, name war no 3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Irene Lepere 6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased December 14 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 8 4 hr. min.

9. Birthplace St. Clair County, Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Foreman

11. Industry or business Terminal Railroad

12. Name Jacob Lepere

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

14. Maiden name Catherine Shubert

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

16. (a) Informant Irene Lepere

(b) Address 3232 E. St. Louis, Mo.

17. (a) Removal (b) Date of removal 10-18-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation E. St. Louis, Ill.

18. (a) Signature of funeral director Charles J. Keenan

(b) Address E. St. Louis, Ill.

19. (a) OCT 19 1948 (b) J. B. Boster
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 18,
year 1948 hour 7 minute 30 A.M.

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

Immediate cause of death Coronary Occlusion;
Coronary Sclerosis.

Due to.....
Due to.....

Other conditions.....
(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?.....
(Specify type of place)

While at work.....
Means of injury.....

23. Signature John E. Smith (M.D. or other) 3

Address..... Date signed 10/29/48

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

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.

Not Embalmed

Signed *Charles H. Hurst*

Licensed Embalmer No. _____

P. O. Address _____

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.