

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18374

#111641

|  |  |   |                                    |   |
|--|--|---|------------------------------------|---|
| BIRTH NO.  |  | REG. DIST. NO. <u>318</u>   | PRIMARY REG. DIST. NO. <u>1003</u> | Registrar's No. <u>4789</u>   |
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u><br>b. COUNTY  |                                    |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri.</u>   |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>2189</u>   |                                    |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1.</u>   |  | d. STREET ADDRESS (If rural, give location) <u>1106 So. Boyle Ave.</u>  |                                    |   |
| 3. NAME OF DECEASED<br>(Type or Print)   |  | a. (First) <u>John</u>  | b. (Middle) <u>DON</u>             | c. (Last) <u>Asburn LA PLANT</u>  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>   |                                    | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>                  |
| 8. DATE OF BIRTH <u>March 16, 1884</u>   |  | 9. AGE (In years last birthday) <u>66</u>   |                                    |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Lead Mines</u>   |                                    | 11. BIRTHPLACE (State or foreign country) <u>Mine LaMont, Mo.</u>                       |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  | 13a. FATHER'S NAME <u>Joseph LaPlant</u>  |                                    |   |
| 13b. MOTHER'S MAIDEN NAME <u>Ann Ward</u>  |  | 14. NAME OF HUSBAND OR WIFE <u>Emma LaPlant</u>   |                                    |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>Unknown</u>  |                                    | 17. INFORMANT'S SIGNATURE OR NAME <u>Pearl Brown</u> ADDRESS <u>3507a So. Jefferson</u> |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.  |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Hypertensive Cardio-vascular disease</u> <u>10 years</u><br>DUE TO (c) <u>Generalized arteriosclerosis</u> <u>10 years</u><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |                                    |   |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION  |                                    | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)   |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>B31X</u>                             |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                    | 21f. HOW DID INJURY OCCUR?  |
| 22. I hereby certify that I attended the deceased from <u>5/20/50</u> 19 <u>50</u> , to <u>5/29/50</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>5/29/50</u> , 19 <u>50</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above. |  |   |                                    |   |
| 23a. SIGNATURE <u>M. G. Amey M.D.</u> (Degree or title)  |  | 23b. ADDRESS <u>1515 Lafayette Ave.,</u>  |                                    | 23c. DATE SIGNED <u>5/29/50</u>   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 24b. DATE <u>5-31-50</u>  |                                    | 24c. NAME OF CEMETERY OR CREMATORY <u>Herculeaneum, Mo.</u>                             |
| 24d. LOCATION (City, town, or county) (State)  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u> ADDRESS <u>4700 Washington Blvd.</u>  |                                    |   |
| DATE REC'D BY LOCAL REG. <u>MAY 31 1950</u>  |  | REGISTRAR'S SIGNATURE <u>J. B. Sasata</u>   |                                    |   |

WRITE PLAINLY—USING 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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....

Student Embalmer

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.