

**FILED NOV 15 1944**  
Registration District No. **878**

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, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Deaconess Hospital. **0**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 weeks.  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME LAWRENCE F. WASHINGTON.

3. (b) If veteran, name war World War II. 3. (c) Social Security No. None.

4. Sex Male. 5. Color or race White. 6. (a) Single, widowed, married, divorced Married.  
6. (b) Name of husband or wife Marjorie Washington. 6. (c) Age of husband or wife if alive 42. years  
7. Birth date of deceased April 29 1906.  
(Month) (Day) (Year)

8. AGE: - Years Months Days If less than one day  
38. 6. 9. hr. min.

9. Birthplace St. Louis, Missouri.  
(City, town, or county) (State or foreign country)

10. Usual occupation Owner... Grand Park Buffet.

11. Industry or business

MOTHER FATHER { 12. Name Charles H. Washington.  
13. Birthplace St. Louis, Missouri.  
(City, town, or county) (State or foreign country)  
14. Maiden name Bertha DeGrand.  
15. Birthplace Alton, Illinois.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Marjorie Washington.

(b) Address 3552 Halliday Ave.,

17. (a) Burial. (b) Date thereof 11/11/44.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery.

18. (a) Signature of funeral director C.R. Lupton & Sons.

(b) Address #7233 Delmar Blv'd.

19. (a) NOV 8 1944 J. J. Bredek  
(Date received local registrar) (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. 3552 Halliday Ave.,  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov, day 8th,  
year 1944. hour 5:05 minute A. M.

21. I hereby certify that I attended the deceased from 10-20-44  
to 11-7-44  
that I last saw her alive on 11-7-  
and that death occurred on the date and hour stated above.

Immediate cause of death TB. Peritonitis Duration

Due to TB Bacilli.

Due to chest

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations TB. All organs of abdomen.  
Of autopsy no

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?..... (2) Means of injury 0

23. Signature PB Cappel md (M. D. or other) md

Address 3284 Washington Ave Date signed 11-7-44

Dr. P. B. Cappel.  
3284 Ivanhoe Ave.,  
HI: 2502.  
10 X 12

**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..... *Clarence A. Murray*.....  
Licensed Embalmer No. *4011*.....  
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.**