

FILED OCT 27 1950

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **34718**
 Registrar's No. **8777**

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

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|-----------------|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. _____ | | State File No. 34718 | | | |
| 1. PLACE OF DEATH a. COUNTY 318 | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE 1003 Missouri | | | | b. COUNTY _____ | |
| b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo. | | c. LENGTH OF STAY (In this place) _____ | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | 2269 | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1 | | | | 26. STREET ADDRESS (If rural, give location) 2210a N. 14th St. | | 0 | | | |
| 3. NAME OF DECEASED a. (First) Le Roy (Type or Print) | | b. (Middle) _____ | | c. (Last) Dapron | | 4. DATE OF DEATH (Month) (Day) (Year) Oct. 14, 1950 | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single | | 8. DATE OF BIRTH 9-5-130 | | | |
| 9. AGE (In years last birthday) 20 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Com. Laborer | | 11. BIRTHPLACE (State or foreign country) Missouri | | 12. CITIZEN OF WHAT COUNTRY? _____ | | | |
| 13a. FATHER'S NAME FLORENCE DAPRON | | 13b. MOTHER'S MAIDEN NAME Minnie Carter | | 14. NAME OF HUSBAND OR WIFE Single | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT'S SIGNATURE OR NAME Minnie Dapron ADDRESS 2210a N. 14th St. | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Subacute Bacterial Endocarditis | | | | | | | |
| | | ANTECEDENT CAUSES due to Micrococci | | | | | | | |
| | | MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ | | | | | | | |
| | | DUE TO (c) _____ | | | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS 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 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) | | | | | |
| 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? H20, 1 | | | | | |
| 22. I hereby certify that I attended the deceased from 9/18 , 19 50 , to 10/14 , 19 50 , that I last saw the deceased alive on 10/14 , 19 50 and that death occurred at 5:15 P.M. , from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE Wm. L. Bryan, M.D. (Degree or title) | | | | 23b. ADDRESS 1515 Lafayette Co. | | 23c. DATE SIGNED 10/16/50 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 24b. DATE 10-18-150 | | 24c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cem. | | 24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. | | | |
| DATE REC'D BY LOCAL REG. OCT 17 1950 | | REGISTRAR'S SIGNATURE J. B. Lasater | | 25. FUNERAL DIRECTOR'S SIGNATURE Goodhart & Goodhart-2228 St. Louis Ave. | | | | | |

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.

Signed.....
Student Embalmer

Signed *Charles J. Lovelace*
Student Embalmer No.....
Licensed Embalmer No. *82777*
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.