

5. No. 2
M-5-43
5-17-39
I X36671

FILED JUL 26 1945
Registration District No. 383

Primary Registration District No. 5655

Registrar's No. 84

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mount Vernon, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 32 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town St. Francois
(If outside city or town limits, write "RURAL")

(d) Street No. 807 Monroe
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William John LaPorte

3. (b) If veteran, name war no

3. (c) Social Security No. unknown

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 10 1884
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8
year 1945 hour 7 minute 40 A.M.

21. I hereby certify that I attended the deceased from June 7, 1945, to July 8, 1945, that I last saw him alive on July 8, 1945, and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>61</u>	<u>5</u>	<u>28</u>	hr. _____ min. _____

Immediate cause of death Pulmonary tuberculosis about 1 yr.

Due to _____

Due to _____

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

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

10. Usual occupation laborer

11. Industry or business _____

12. Name Ferdinand Lagente

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

14. Maiden name Julia Lagente

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

Major findings: For adv. emphysema of lungs. Silicosis. Chronic of autopsy pneumonia. Caseous tubercular infiltration of lung

16. (a) Informant E. McMichael, Record Clerk

(b) Address Mo. State San, Mount Vernon, Mo.

17. (a) Flat River (b) Date thereof July 9 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flat River

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? _____

18. (a) Signature of funeral director Caldwell Bros.

(b) Address Flat River, Mo.

19. (a) 7-10-45 (b) Andy Crawford
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Charles A. Crashe M. B. of other _____
Address St. Vernon, Mo. Date signed 7-8-45

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

1338

RECEIVED

District Health Officer No. 6;
District File Number 745-786
Date Filed JUL 24 1945

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 *H. H. Fessett*

Licensed Embalmer No. *2201*

P. O. Address *W. F. L. L. L.*

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.