DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40696

Registration District No. 774 Primary Registration District No. 4465 Registrar's No. 905

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH
(a) County St Francois
(b) City or town Flat River (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 11

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Francois
(c) City or town Flat River (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME John Ferdinand LaPorte
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan 21 1861 (Month) (Day) (Year)
8. AGE: Years 78 Months 9 Days 15 If less than one day hr. min.
9. Birthplace St Genevieve Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation Retired
11. Industry or business at home
FATHER 12. Name William LaPorte
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Zalumondier
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant's own signature W. J. LaPorte
(b) Address
17. (a) Catholic Cemetery (Burial, cremation, or removal) (b) Date thereof 11-6-39 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director Caldwell Bros
(b) Address Flat River Mo
19. (a) 11-4-39 (Date received local registrar) (b) C B Farrar MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 4th year 1939 hour 7 minute 30 P M.
21. I hereby certify that I attended the deceased from May, 1937, to Nov 4, 1939; that I last saw him alive on 11-4-39, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death aortic mitral regurgitation	unk
Due to Chr. nephritis, ascites arterio-sclerosis	unk
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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Major findings:
Of operations none
Of autopsy none

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? (e) Means of injury
23. Signature H O Gaebe MD (M. D. or other)
Address Desloge Mo Date signed 11-9-39

(Licensed Embalmer's Statement on Reverse Side)

I X19511

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

40696
Do not use this space.

1. PLACE OF DEATH
(a) County St Francois Registration District No. 774
(b) Township Primary Registration District No. 4465 Registered No.
(c) City Flat River (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Ferdinand Laparte
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE Years 78 Months 9 Days 15 If LESS than 1 day, ...hrs. or ......min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 12/7 1939 C. B. Farrar Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 4 1939

22. I HEREBY CERTIFY, That I attended deceased from ......, 19...... to ......, 19......
I last saw h...... alive on ......, 19...... Death is said to have occurred on the date stated above, at ......m.
The principal cause of death and related causes of importance were as follows: Date of onset

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury ......, 19......
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) H. C. Grace, M. D.
(Address) Desloge Mo

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED