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

Do not use this space.

26157

1. PLACE OF DEATH

County..... Registration District No. 791 File No. .....

Township..... Primary Registration District No. 1003 Registered No. 7812

City St. Louis (No. City Hospital St. ..... Ward)

6648

2. FULL NAME Baby Antal

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 20 - 1927

7. AGE: YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or 35 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Nor Known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Nor Known
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Isabella Antal
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

14. INFORMANT Hospital Information
(Address) C Rowan City Hospital

15. FILED SEP -1 1927, 19.. Mary C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 20 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1927 to Aug 20, 1927 that I last saw him alive on Aug 20, 1927, and that death occurred, on the date stated above, at 3:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Prematurity
about 6½ months
159 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 161A (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Henry C Westerman, M. D

8/26, 1927 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: POTTERS FIELD.
DATE OF BURIAL: 9-2-1927

20. UNDERTAKER: E Shannon
ADDRESS: 1425 Carol

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.

antal