

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

Do not use this space.

1. PLACE OF DEATH <sup>Feb 15 1935</sup>

**791**

**7538**

County.....

Registration District No.....

File No.....

Township.....

Primary Registration District No. **1003**

Registered No. **8005**

City *St. Louis Mo*

(No. *City Hospital 2*)

St.....

Ward.....

2. FULL NAME *Baby Austin*

(a) Residence, No. *223 1/2 - Franklin 21*

(Usual place of abode)

Ward.....

(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 *Female*

4. COLOR OR RACE *Colored*

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) *Feb. 16<sup>th</sup> 1935*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, 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) *St. Louis Mo*

13. NAME *Infant*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

15. MAIDEN NAME *Margaret Austin*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

17. INFORMANT (ADDRESS) *Baby 2945 - Lawton Blvd*

18. BURIAL, CREMATION, OR REMOVAL PLACE *CITY CEMETERY* DATE *MAR - 1 1935*

19. UNDERTAKER (ADDRESS) *David J. Lassar City Hospital*

20. FILED *FEB 28 1935*

Registrar *J. Bredeck*

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb. 16<sup>th</sup> 1935*

22. I HEREBY CERTIFY That I attended deceased from *2 - 16 - 1935* to *2 - 16 - 1935*

I last saw her alive on *2 - 16 - 1935* Death is said

to have occurred on the date stated above, at *3:30 a.m.*

The principal cause of death and related causes of importance were as follows:

*Asphyxiated newborn*

Date of onset

Other contributory causes of importance:

*Twisted cord around neck of baby*

Name of operation

What test confirmed diagnosis? *Clinical* Was there an autopsy? *Yes*

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) *J. Allen Black*

(Address) *2945 - Lawton Blvd*

M. D.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

