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.

AUG 9 1935

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

Do not use this space.

791

21709

1. PLACE OF DEATH

County ..... Registration District No. 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 6069

City St Louis (No. City Hosp #1 St. ..... Ward)

2. FULL NAME Baby Antrobus

(a) Residence, No. 1515a St. Cass Ward. 26 (If nonresident, give city or town and State)
(Usual place of abode)

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 F | 4. COLOR OR RACE W | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 19 - 1935

7. AGE YEARS 0 MONTHS 0 DAYS 0 If LESS than 1 day, 0 hrs. or 30 min.

OCCUPATION

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

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

FATHER

13. NAME Olin Antrobus

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis Mo

MOTHER

15. MAIDEN NAME Bertha Koehler

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Quincy Ill.

17. INFORMANT (ADDRESS) Hosp Ing Mt Kent City Hosp #1

18. BURIAL, CREMATION, OR REMOVAL

PLACE City Crematory DATE 7/19/35 19

19. UNDERTAKER (ADDRESS) David Van Fossan City Hosp #1

20. FILED JUL 16 1935 19 J F Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/19, 1935

22. I HEREBY CERTIFY, That I attended deceased from 6/19, 1935, to 6/19, 1935

I last saw her alive on 6/15, 1935. Death is said to have occurred on the date stated above, at 9:15 a.m.

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

	Date of onset
Stillborn	
premature (5½ mo)	

Other contributory causes of importance:

157

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) L B Brod, M. D.

(Address) City Hosp #1