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

REC'D AUG 12 1938

24027
Do not use this space.

791
1003
6721

1. PLACE OF DEATH
(a) County ..... Registration District No. .....
(b) Township ..... Primary Registration District No. ..... Registered No. .....
(c) City St. Louis, Mo. (d) Street No. St. Ann's Hospital 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 Stillborn Wiese 260
(a) Residence, No. ..... St. NR Florissant, Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
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) July 27 1938

7. AGE — YEARS — MONTHS — DAYS — 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) St. Louis, Missouri 0

FATHER
13. NAME 9
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) NR 0

MOTHER
15. MAIDEN NAME Ida Wiese
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Florissant, Missouri

17. INFORMANT (ADDRESS) S ister Zoe St. Ann's Hospital

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary Cemetery DATE July 28 1938

19. FUNERAL DIRECTOR (ADDRESS) Charles Hatcher 5301 Page Blvd.

20. FILED JUL 27 1938 J. F. Bredeck Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JULY 27 1938

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 4:50 A.m.
The principal cause of death and related causes of importance were as follows:

Date of onset

Intra uterine
Asphyxiation

Other contributory causes of importance:
Anencephalitis
Monstrosity
(Absence of Brain)

Name of operation none 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) John B. O'Neill, M. D.
(Address) 1222 Missouri Theatre

(Licensed Embalmer's Statement on Reverse Side)

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.

50M-7-20-37 I X12004

## STATEMENT BY LICENSED EMBALMER

I, ....., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

**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.)**