

REC'D MAR 13 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791
1003

4651
Do not use this space.

1. PLACE OF DEATH

(a) County / Registration District No.
 (b) Township Primary Registration District No. Registered No. **1344**
 (c) City St. Louis, Missouri (d) Street No. City Hospital No. 1 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.

D, 13091
 2. PRINT FULL NAME BABY FERNANDEZ
 (a) Residence, No. 612 Lafayette St. [23] (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE whit 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 6th 1938
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
0 2 3
 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. nil
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/9/39, 19...
 22. I HEREBY CERTIFY, That I attended deceased from 12/6/38 to 2/9/39, 19...
 I last saw h. her alive on 2/9/39, 19... Death is said to have occurred on the date stated above, at 4 p. m.
 The principal cause of death and related causes of importance were as follows:

Bronchial pneumonia
Primary
Premature birth
 Date of onset

12. BIRTHPLACE (CITY OR TOWN) St. Louis, Missouri
 (STATE OR COUNTRY)

FATHER 13. NAME ANGELE FERNANDEZ

14. BIRTHPLACE (CITY OR TOWN) ILLINOIS
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME MABEL MC KENZIE

16. BIRTHPLACE (CITY OR TOWN) MISSOURI
 (STATE OR COUNTRY)

17. INFORMANT HOSP. INFO. M. KENT
 (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Lakewood Cem DATE 2/11/39

19. FUNERAL DIRECTOR (NAME) A.W. Mc Laughlin
 (ADDRESS) 2301 Lafayette

20. FILED J. F. Brudick
 Local Registrar

Other contributory causes of importance:
107a

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? no

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? h
 If so, specify h
 (Signed) E. L. Engel, M. D.
 (Address) CITY HOSPITAL NO. 1

FEB 11 1939

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.

John Smith

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 with the above constitutes grounds for revocation of license.)

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