

REGD JUL 12 1939 791
Registration District No. 1003

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 1 day years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 310 East Espenschied
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2
year 1939 hour 7:30 minutes A. M.

21. I hereby certify that I attended the deceased from 6/2/39
_____, 19____, to 6/2, 1939
that I last saw h_____ alive on 6/2/39
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Stillborn

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature H. L. ... (M. D. or other) _____
Address City Hospital Date signed 6-2-39

3. (a) PRINT FULL NAME: Baby De Geare
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex ? 5. Color or race W
6. (a) Single, widowed, married, divorced _____
(b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 2 1939
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.
Stillborn

9. Birthplace St. Louis
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER { 12. Name Clarence De. Gear O
13. Birthplace Missouri O
(City, town, or county) (State or foreign country)
14. Maiden name Louette Mulligan
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hosp Info. M. Sullivan

(b) Address _____

17. (a) Burial (b) Date thereof 6-30-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Frank Van ...
(b) Address City Hosp ...

19. (a) _____ (b) _____
(Informant's local address) (Registrar's address)

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.

JUN 28 1939

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.