

Registration District No. 2009

Primary Registration District No.

1. PLACE OF DEATH: 1003
 (a) County _____
 (b) City or town ST. LOUIS MO
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: ST JOHN'S HOSP
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 DAYS
 (Specify whether years, months or days)
 In this community 2 DAYS

3. (a) PRINT FULL NAME INFANT LOCHBIHLER 214
 3. (b) If veteran, name war NONE
 3. (c) Social Security No. NONE

4. Sex FEMALE
 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased SEPT 19 1939
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 2 hr. _____ min.

9. Birthplace ST LOUIS MO
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOYER FATHER {
 12. Name WILLIAM LOCHBIHLER
 13. Birthplace ST LOUIS MO
 (City, town, or county) (State or foreign country)
 14. Maiden name GEORGINA GRIMES
 15. Birthplace ST LOUIS MO
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature WILLIAM LOCHBIHLER
 (b) Address 4571 WICHITA ST

17. (a) BURIAL (b) Date thereof SEPT 22 39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director KRIBBS HAUSER
 (b) Address 4228 SAKAMITHWAY

19. (a) SEP 22 1939 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County 1
 (c) City or town ST. LOUIS 19
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4571 WICHITA AVE
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month SEPT day 21
 year 1939 hour 6 minute 30 P.M.
 21. I hereby certify that I attended the deceased from 9-19
 _____, 1939, to 9-21, 1939,
 that I last saw her alive on 9-21, 1939,
 and that death occurred on the date and hour stated above.

Immediate cause of death: Prematurity
 Due to _____
 Due to _____
 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.

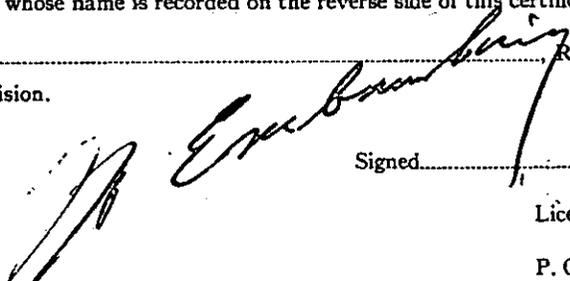
22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (a) Means of injury _____
 23. Signature [Signature] (M. D. or other) [Signature]
 Address 3720 Washington St Date signed 9-22-39

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.

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.