

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.

NOV 13 1939
Registration District No. 791

Primary Registration District No. 7008

1. PLACE OF DEATH:

(a) County 1
(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. Louis Children's 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 years, months or days)

3. (a) PRINT FULL NAME Jackie Reid 30

3. (b) If veteran, name war child
3. (c) Social Security No. child

4. Sex m
5. Color or race w
6. (a) Single, widowed, married, divorced child

6. (b) Name of husband or wife child
6. (c) Age of husband or wife if alive child years

7. Birth date of deceased 9 28 39
(Month) (Day) (Year)

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

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

10. Usual occupation child

11. Industry or business child

12. Name Roy Reed 0

13. Birthplace Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Dorothy Mergelkamp

15. Birthplace St. Louis County, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature F. Hoppe
(b) Address 500 S. Kings Highway

17. (a) Removal (b) Date thereof 10-8-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Genevieve Mo.

18. (a) Signature of funeral director Albert H. Hoppe Inc.
(b) Address 4700 Washington Blvd.
19. (a) OCT 3 1939
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 1
(c) City or town St. Genevieve NR
(If outside city or town limits, write "RURAL")
(d) Street No. 799 La Part St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 2nd
year 1939 hour 7 minute 15 P.M.

21. I hereby certify that I attended the deceased from 10-1-39 to 10-2-39;
that I last saw him alive on 10-2-39;
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal atresia

Due to malformation

Due to 157

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations Anastomosis

Of autopsy

Duration
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) (e) Means of injury

23. Signature R. D. Bluth (M. D. or other)
Address 500 S. Kings Highway Date signed

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.

No Embalmed
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.