

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **1282**

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:
St. Louis Childrens Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **7 Hrs.**
 (Specify whether
 In this community **Life**
 years, months or days)

3. (a) PRINT FULL NAME **Phyllis M. Sigg**

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 **Single**

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

7. Birth date of deceased **June 28 1939**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 7 10 hr. min.

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

10. Usual occupation **Nil**

11. Industry or business _____

12. Name **Elmer Sigg**

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

14. Maiden name **Eleanor Ballinger**

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

16. (a) Informant's own signature **Elmer Sigg**

(b) Address **8202 A. Minnesota ave.**

17. (a) **Burial** (b) Date thereof **Feb. 9, 1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olive Cemetery**

18. (a) Signature of funeral director **C. Hoffmeister & Co.**

(b) Address **7814 S. Broadway**

19. (a) **FEB 8 1940** (b) **J. B. Brudick**
 (Date received local registrar) (Registrar's signature)

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. **8202 A. Minnesota ave**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **6**
 year **1940** hour **7** minute **00** P. M.

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

Immediate cause of death **Intestinal obstruction**

Due to **1220**

Other conditions **Ether anesthesia**
 (Include pregnancy within 3 months of death)
Operated Feb 6 1940

Major findings: **Intussusception**

Of operation _____
 Of autopsy **yes**

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) (M. D. or other)
 Means of injury _____

23. Signature **Alfred Perry** (M. D. or other)
 Address **Deputy Coroner** Date signed **2.7.40**

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

Linnis C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S Broadway

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.