

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8818**
Registrar's No. **2301**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **2301**

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. Anthonys Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Infant Stika**

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

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 **Mar. 7, 1940**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. **15** min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name **James Stika**

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

14. Maiden name **Agnes Radeke**

15. Birthplace **Illinois** (City, town, or county) (State or foreign country)

16. (a) Informant **James Stika**

(b) Address **1803 Lami Street**

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

(c) Place: burial or cremation **Old S. Peter & Paul**

18. (a) Signature of funeral director **Wm. C. Mayhew**

(b) Address **1926 Allen Ave.**

19. (a) **MAR 8 1940** (b) **J. B. Redbeck**
(Date received local registrar) (Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURY** (b) County _____
(c) City or town **St. Louis,** **23**
(If outside city or town limit write "RURAL")
(d) Street No. **1803 Lami Street**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **7**
year **1940** hour **4:20** minute **15** M.

21. I hereby certify that I attended the deceased from **March 1, 1940** to **March 1, 1940**

that I last saw her alive on **March 1, 1940** and that death occurred on the date and hour stated above.

Immediate cause of death _____
undetermined

Due to **Child lived about 15 minutes after birth death**

Due to **probably due to trauma at time of delivery.**

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

Major findings: Of operations _____
160

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: **no**

(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 **W. B. Redbeck** (M. D. or other) **MD**

Address **3318 S Grand** Date signed **3-8-40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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

Benj. L. Duman

Licensed Embalmer No. 2272

P. O. Address 1924 Allen

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.