

Registration District No. **791**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(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 JOHNS. HOSPITAL. 1**
(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) **4 3/4**

3. (a) PRINT **INFANT**
FULL NAME. **CARROLL & LUCILLE AWALT.**

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

4. Sex **MALE** 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. **AUG. 30 1940**
(Month) (Day) (Year)

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

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

10. Usual occupation. **NONE**

11. Industry or business.....

MOTHER FATHER { 12. Name. **CARROLL AWALT.** 1

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

14. Maiden name. **LUCILLE MITCHELL.**

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

16. (a) Informant. **Carroll Awalt.**

(b) Address. **4229 W. Pine**

17. (a) **BURIAL.** (b) Date thereof. **8. 31. 40.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. **RIDGEWAY ILL**

18. (a) Signature of funeral director. **L. M. Muller**

(b) Address. **5115 DELMAR BLVD**

19. (a) **AUG 31 1940** (b) **J.F. Budek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County.....
(c) City or town. **ST LOUIS. 19**
(If outside city or town limits, write "RURAL")
(d) Street No. **4229 WEST PINE AVE**
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **30**
year **1940** hour **7** minute **P** M.

21. I hereby certify that I attended the deceased from **Aug - 30**
1940 to **Aug 30** **1940**
that I last saw him alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death
Prematurity - 6 mo gestation.

Due to.....
Due to.....

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
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 **Matthew W. Weir** (M. D. or other) **MD**
Address **634 No. Grand Ave** Date signed **Aug 31/40**

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.

5 HOURS OLD
DID NOT EMBALM

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, fact should be so stated above.