

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. _____

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

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. **5610 Enright ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

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

3. (b) If veteran, name war **None** 8. (c) Social Security No. **None**

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 **September 14 1940**
(Month) (Day) (Year)

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

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

10. Usual occupation **Nil**

11. Industry or business _____

12. Name **Richard Prest**

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

14. Maiden name **Mary Frances St. Clair**

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

16. (a) Informant **Richard Prest**

(b) Address **5610 Enright ave.**

17. (a) **Burial** (b) Date thereof **Sept. 16, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address **7814 S Broadway**

19. (a) **SEP 16 1940** (b) **J. P. Redbeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **15**
year **1940** hour **3** minute **45 a. M.**

21. I hereby certify that I attended the deceased from **Sept 14/40**
1940, to **Sept 15**, **1940**;
that I last saw him alive on **Sept 15**, **1940**
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Prematurity - 7 mos

Due to _____

Due to _____

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

Duration

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy **None**

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 **Maxwell W. Wain** (M. D. or other) **MD**

Address **63470 Grand ave** Date signed **9/16/40**

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

MOTHER FATHER

6342 Broad
914 Franklin 2029
Park View
0424

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 Linus C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broad

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.