

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

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34033**
Registrar's No. **8730**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis Maternity Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Hill, Infant Boy

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 10 21 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 If less than one day 55 hr 10 min

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

10. Usual occupation _____

11. Industry or business _____

12. Name Perry Hill

18. Birthplace Arlington Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Marie Alice Dunn

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

16. (a) Informant's own signature St. Louis Maternity Hospital

(b) Address 630 S. Kingshighway

17. (a) Burial (b) Date thereof 10/23/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director E. R. Sieber

(b) Address 2849 No. Euclid

19. (a) OCT 23 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis Missouri 20
(If outside city or town limits, write "RURAL")
(d) Street No. 2533 No. Market St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 22
year 1940 hour 6 minute 55 P.M.

21. I hereby certify that I attended the deceased from October 21, 1940, to October 22, 1940,
that I last saw him alive on October 22, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death ADRENAL INSUFFICIENCY

Due to _____

Due to _____

Other conditions (Include pregnancy within 8 months of death) _____

Major findings: Of operations ADRENAL HEMORRHAGE, KIDNEY

Of autopsy ADRENAL, SUBARACHNOID, AND KIDNEY HEMORRHAGES

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 E. R. Sieber (M. D. or other) MD

Address 630 S. Kingshighway Date signed 10-23-40

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.

Signed.....

Al Mayfield
3077

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.