DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36826

Registration District No. 7911 — Primary Registration District No. 1003 — Registrar's No. 9099

FILED DEC 11 1940

1. PLACE OF DEATH:

(a) County

(b) City or town Saint Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Saint Louis Maternity Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days
(Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town Saint Louis
(If outside city or town limits, write "RURAL")

(d) Street No. ~~630 So. Kingshighway~~ 4095 Kingsborough
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Infant Boy Cejka

3. (b) If veteran, name war Nil

3. (c) Social Security No. Nil

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 October 24, 1940 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
		2	hr. min.

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

10. Usual occupation Nil

11. Industry or business 0

MOTHER

12. Name Otto Frank Cejka

13. Birthplace Saint Louis, Missouri (City, town, or county) (State or foreign country)

FATHER

14. Maiden name Libbie Bednar

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

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

(b) Address 630 So. Kingshighway Blvd.

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11-5-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Lakewood Park

18. (a) Signature of funeral director Wm. E. Moydell

(b) Address 1926 Allen Ave.

19. (a) NOV 5 1940 (Date received local registrar) **(b)** J. F. Broderick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 26th year 1940 hour 2:25 minute PP M.

21. I hereby certify that I attended the deceased from 9:10 AM October 24, 1940 to 2:25 PM 10/26 1940 that I last saw him alive on 10/26/40 2:25 PM, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Prematurity (36 wks. gestation)	
Due to: Hemorrhagic disease of the new born	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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:

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address 3720 Washington Ave. Date signed 10/31/40

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.

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.