DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37004

FILED DEC 11 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 9277

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 1
(Specify whether)
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town Saint Louis 19
(If outside city or town limits, write "RURAL")

(d) Street No. ~~630 S. Kingshighway Blvd.~~ 4254 Aline
(If rural, give location)

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

3. (a) PRINT FULL NAME Infant Boy Feld

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased October 28, 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 0

11. Industry or business

FATHER
12. Name Albert Feld
13. Birthplace Saint Louis, Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ethel Brown
15. Birthplace Kandas City, Kansas (City, town, or county) (State or foreign country)

16. (a) Informant's own signature St. Louis Maternity Hospital
(b) Address 630 S. Kingshighway Blvd.

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation W. U. Dept of Pathology

18. (a) Signature of funeral director St. L. Maternity Hosp
(b) Address

19. (a) NOV 12 1940 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 31
year 1940 hour 12:15 minute A. M.

21. I hereby certify that I attended the deceased from 11:45 P.M. October 28, 1940 to 12:15 A.M. 10/31 40 that I last saw him alive on 10/31/40, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death prematurity - 26 wk. gestation	
Due to	
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 E. N. Sieber (M. D. or other) M.D.
Address 630 S. Kingshighway Date signed 10-31-40

(Licensed Embalmer's Statement on Reverse Side)

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.

Rev. 5-17-39
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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 with the above constitutes grounds for revocation of license.)

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