

Registration District No. **701**

Primary Registration District No. **1003**

Registrar's No. **10651**

I. PLACE OF DEATH:

(a) County **St Louis**
(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 Mary's Infirmary**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 hrs**
(Specify whether years, months or days)

8. (a) PRINT FULL NAME **Infant Whirley**

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

4. Sex **Male** 5. Color or race **Colored** 6. (a) Single, widowed, married, divorced **Newborn**

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

7. Birth date of deceased **November 29th 1940**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day **4 hrs** min _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **Frank O'Neil Whirley**

13. Birthplace **Charles Xon** **Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Sadie Thomas**

16. Birthplace **Park City** **Iowa**
(City, town, or county) (State or foreign country)

16. (a) Informant **Sadie Whirley** Mother

(b) Address **4368^a Evans** **St Louis Mo**

17. (a) _____ (b) Date thereof **12-27-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **City Cem**

18. (a) Signature of funeral director **Wm Hamilton**

(b) Address **City Health Dept**

19. (a) **DEC 28 1940** (b) **J. J. Borden**
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St Louis** **11**
(If outside city or town limits, write "RURAL")
(d) Street No. **4368^a Evans**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **29th**
year **1940** hour **7** minute **15 A** M.

21. I hereby certify that I attended the deceased from **3:15 AM**
11-29-40, 19____, to **7:15 AM 11-29, 1940**;
that I last saw him alive on **11-29-40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Prenatal Toxemia

Due to _____

Toxemia of Pregnancy of mother

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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 **Lucius J. Davis** (M. D. or other) **MD**

Address **St. Mary's Infirmary** Date signed **11-29-40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.