

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

FILED OCT 18 1941 91

Registration District No. Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town ST. LOUIS
(c) Name of hospital or institution: Mo Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000
(c) City or town ST. LOUIS 9 11
(d) Street No. Mo Baptist Hospital
1923 E PRAIRIE AVE
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

CHARLINE MARIE ZUBIANA

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

4. Sex F, 5. Color or race W, 6. (a) Single, widowed, married, divorced, AS single
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive years

7. Birth date of deceased 8-31-1941 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day 18 hr. min.

9. Birthplace ST. LOUIS MO (City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business

12. Name CHARLES ZUBIANA JR

13. Birthplace ST. LOUIS MO (City, town, or county) (State or foreign country)

14. Maiden name DOROTHY HUDSON

15. Birthplace SPRINGFIELD ILL (City, town, or county) (State or foreign country)

16. (a) Informant CHARLES ZUBIANA JR

(b) Address 1923 E PRAIRIE AVE

17. (a) BURIAL (b) Date thereof 9-2-41 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director SULLIVAN

(b) Address 49 N. EUCLID AVE

19. (a) 2 1941 (Date received local registrar) (b) J. Brudeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1st year 1941 hour 8 minute 9 M.

21. I hereby certify that I attended the deceased from Aug 31 1941 to Sept 1st 1941

that I last saw him alive on Aug 31 1941 and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Atelectasis

Due to

Other conditions

Major findings: Of operations

Of autopsy

Duration
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?

While at work? (Specify type of place) (e) Means of injury

23. Signature D. A. Promser (M. D. or other)

Address 3121 N Grand Date signed Sept 1

W. H. Johnson
3121 N. Grand
Tuesday 10-12
Albany 2233
771244

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.

Signature *Albert Mayfield*
Licensed Embalmer No. *3977*
P. O. Address *St. Louis Mo*

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, fact should be so stated above.