

FILED NOV 4 1942

Registration District No. **318**

Primary Registration District No. **100**

Registrar's No. **8835**

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

1. PLACE OF DEATH:

(a) County.....
(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. Johns Hospital
(If not in hospital or institution, write street number or location)
Six Hours
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County.....
(c) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No..... **1001 Veronica Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Baby Wind**

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, **single**

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

7. Birth date of deceased **Oct. 23 1942**
(Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

12. Name **William Wind**

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

14. Maiden name **Louise Deuser**

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

16. (a) Informant **William Wind**
(b) Address **1001 Veronica Ave.**

17. (a) **Burial** (b) Date thereof **Oct. 24**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery Bromschwig Und. Co.**

18. (a) Signature of funeral director **4746 West Florissant Ave.**
(b) Address

19. (a) **OCT 24 1942** (b) **J. F. [Signature]**
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **23**
year **42** hour..... minute..... M.

21. I hereby certify that I attended the deceased from **Oct 23**
19 **42** to..... 19.....
that I last saw him alive on **Oct 22**
and that death occurred on the date and hour stated above.

Immediate cause of death **Premature**
7 months Duration

Due to **Low insertion of placenta**

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?

While at work?..... (Specify type of place)
(e) Means of injury.....
Signature **W. P. [Signature]** (M. D. or other) **MD**
Address **8363 Halle Ferry** Date signed **Oct 23 1942**

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.

Albert G. Hoffa

Licensed Embalmer No. 2971

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, fact should be so stated above.