

S. No. 2
M-5-42
5-17-39
X328

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4298**
Registrar's No. **1649**

LEG MAR 2 1943 18

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis Desloge Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **0000**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL") **919**
(d) Street No. **4625 Laclede Ave**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Henry- female infant**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **NONE**

4. Sex **Female** 5. Color or face **White**
6. (a) Single, widowed, married, divorced **0**

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

7. Birth date of deceased **Feb. 17 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
20 hr. 35 min.

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

10. Usual occupation **newborn**

11. Industry or business _____

12. Name **JOE F. HENRY**

13. Birthplace **VASPER COUNTY ILLINOIS**
(City, town, or county) (State or foreign country)

14. Maiden name **ELSIE MCCONAVERAY**

15. Birthplace **MT. VERNON ILLINOIS**
(City, town, or county) (State or foreign country)

16. (a) Informant **Joe F. Henry**

(b) Address **4625 LACLEDE**

17. (a) **BURIAL** (b) Date thereof **2-19-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **VAL HALL'S CEMETERY**

18. (a) Signature of funeral director **ALBERT H. Hoppe INC**

(b) Address **4700 WASHINGTON BLVD**

19. (a) **FEB 19 1943** (b) **J. F. Bruders**
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **18**
year **1943** hour **3** minute **00 P.M.**

21. I hereby certify that I attended the deceased from **Feb 17**
1943, to **Feb 18 1943**
that I last saw h. **CR** alive on **Feb 18 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Bilateral atelectasis** Duration **20'**

Due to **15'**
Due to _____

Other conditions **Patent ductus arteriosus**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy **as above**
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 **John P. Ferguson M.D.**
11225 S. Grand (M. D. or other) **Ind.**
Address _____ Date signed **2/19/43**

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

MOTHER FATHER

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.

Not Embalmed

Signed *Albert N. Hopper*

Licensed Embalmer No. *1861*

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.