

FILED JUN 9 1943

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4987**

1. PLACE OF DEATH:

(a) County **St. Louis.**

(b) City or town **Jennings, Mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Christian Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____

(c) City or town **Jennings,**
(If outside city or town limits, write "RURAL")

(d) Street No. **7517 Calvin Ave.**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Infant Steibel.**

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 **0**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **May 28, 1943**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
		1	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name **Raymond Steibel.**

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

14. Maiden name **Virginia Owens.**

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

16. (a) Informant **Raymond Steibel.**

(b) Address **7517 Calvin Ave.**

17. (a) **Burial.** (b) Date thereof **5-29-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Arthur J. Donnelly**

(b) Address **3840 Lindell Blvd**

19. (a) **MAY 28 1943** (b) **J. W. Bruders**
(Date received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **29th**
year **1943** hour **12:30** minute **0** M.

21. I hereby certify that I attended the deceased from **5/28/43**
_____ 19 _____ to **5/29/43** _____ 19 _____
that I last saw her alive on **5/29/43** _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death **Prematurity**
157
Due to _____
Due to _____

Other conditions **Placental Prematurity with Polyhydramnios + rhesus toxicity**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy **Prematurity**

Duration **1 day**

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

22. Signature **J. W. Bruders** (M. D. or other) _____
Address **6807 W. Locust** Date signed **5/29/43**

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 Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3840 Lindell

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.