

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Park Lane Hospital
(If not in hospital or institution, write street number or location) **0**
(d) Length of stay: In hospital or institution. **0**
(Specify whether
In this community **0**
years, months or days)

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

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

4. Sex **female** 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 **Sept. 23, 1943.**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 hr. **00** min.

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

10. Usual occupation **Nil.**

MOTHER FATHER { 11. Industry or business _____
12. Name **Alfred Korte**
13. Birthplace **Florissant, Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Frances Keeven**
15. Birthplace **Florissant, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Alfred Korte**

(b) Address **790 Clark St., Florissant, Mo**

17. (a) **Burial** (b) Date thereof **Sept. 24/43**
(Burial, cremation, or removal) **Sacred Heart C.S.P.,**
(c) Place: burial or cremation **Florissant, Mo.**

18. (a) Signature of funeral director **Jos. W. Clark**

(b) Address **1125 Hodiamont Ave.**

19. (a) **SEP 24 1943** (b) **J. T. Bradeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**
(c) City or town **Florissant,**
(If outside city or town limits, write "RURAL")
(d) Street No. **790 Clark St.,**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **23**
year **1943** hour **2.30** minute **P.M.** M.

21. I hereby certify that I attended the deceased from **9-23-43**
_____ 19 _____ to **9-23-43** 19 _____;
that I last saw h. **ER** alive on **9/23-43**, 19 _____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Brain tumor
causing meningitis
Due to **6 months duration**

Due to _____
General weakness of
Other conditions _____
(Include pregnancy within 3 months of death) **see other**

PHYSICIAN
Major findings: _____
Of operations **none**
Of autopsy **none**
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) **none**
(b) Date of occurrence **none**
(c) Where did injury occur? **none**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
no

While at work? _____ (Specify type of place)
(e) Means of injury **none**

23. Signature **Dr. J. H. Hammond** (Date) _____
Address **2739 N. Grand** Date signed **9-23-43**

Dr. M.F. Hartmann,
2739 N. Grand Blvd.,
W.R. 1800.
2-4 or 7-8 P.M.

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.

NO Embalming

Signed.....

Geo. W. Clark

Licensed Embalmer No..... **1661**

P. O. Address..... **1125 Hodiament Ave.,**

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.