

S. No. 2
M-5-43
v. 5-17-39
p. 1 X36871

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16750**
Registrar's No. **4845**

FILED JUN 1 1944
318

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

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Saint Louis Maternity 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

3. (a) PRINT FULL NAME Infant Male Senn

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 0

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

7. Birth date of deceased May 25, 1944
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name Peter W. Senn

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

14. Maiden name Eunice Deyo

15. Birthplace Auburn New York
(City, town, or county) (State or foreign country)

16. (a) Informant Saint Louis Maternity Hosp.
(b) Address 630 S. Kingshighway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26 44
(Month) (Day) (Year)

(c) Place: burial or cremation St. Mothering Cem.

18. (a) Signature of funeral director J. F. Bredek
(b) Address 1905 Grand Blvd

19. (a) MAY 26 1944 (Date received local registrar's certificate) J. F. Bredek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 8629 Brinker Street
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25
year 1944 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 25, 1944 to May 25, 1944; that I last saw him alive on May 25, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Undetermined

Due to prematurity, 30 wks.

Due to _____

Other conditions (Include pregnancy within 3 months of death) 137

Major findings: _____

Of operations _____

Of autopsy _____

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 J. F. Bredek (M. D. or other) 5/26/44
Address 630 S. Kingshighway Date signed 5/26/44

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

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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.....

Licensed Embalmer No.....

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.