

FILED JUL 8 1944

Registration District No. **818** 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:  
St. Louis City Hospital  
(If not in hospital or institution, write street number or location)

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

In this community..... 0  
years, months or days

3. (a) PRINT FULL NAME Baby Smith

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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..... May 24th, 1944  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1 hr. 0 min.

9. Birthplace St. Louis, Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business.....

MOTHER FATHER { 12. Name Raymond Smith

13. Birthplace Missouri 0  
(City, town, or county) (State or foreign country)

14. Maiden name Clara Roy

15. Birthplace Missouri 0  
(City, town, or county) (State or foreign country)

16. (a) Informant M. Renard.

(b) Address St. Louis City Hospital

17. (a) (b) Date thereof 6-29-44  
(Specify cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

18. (a) Signature of funeral director M. J. White

(b) Address City Hospital No.

19. (a) JUL 28 1944 J. F. Bindeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County..... 100

(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL") 49

(d) Street No. 5557 Manchester  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No) 0  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24th  
year 1944 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 24th  
1944 to May 24th, 1944:  
that I last saw her alive on May 24th, 1944:  
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity 7 mo.  
15 1/2  
Due to.....  
Due to.....  
Other conditions Placenta previa 7 mo.  
(Include pregnancy within 3 months of death)

Duration  
7 mo.  
7 mo.  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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 Robert E. Holt, M.D. 0  
Address 1515 Lafayette 5/27/44  
(M. D. or other) (Date)

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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.**