

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

FILED SEP 8 1944
Registration District No. **8 1 3**

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:
Boxhead Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 hours
(Specify whether)

In this community 25 yr.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 9 6

(d) Street No. 4923 Natural Bridge
(If rural, give location)

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

3. (a) PRINT FULL NAME La Donna Jo Blanchfield

3. (b) If veteran, name war No

3. (c) Social Security No. none

4. Sex f **5. Color or race** W **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: 9 31 44
(Month) (Day) (Year)

8. AGE: Years — Months — Days — If less than one day 9 hr. min.

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

10. Usual occupation none

11. Industry or business

12. Name Donald J. Blanchfield

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

14. Maiden name Berna di Cuba

15. Birthplace Spring Hill, Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Donald Blanchfield

(b) Address 4823A Nat. Bridge Rd.,

17. (a) Burial **(b) Date thereof** Sept. 1/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.,

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

(b) Address 1125 Hodiamont Ave.,

19. (a) SEP 1 1944 **(b) J. F. Briedeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 31
year 1944 hour 9.00 minute A.M.

21. I hereby certify that I attended the deceased from 8-31-44
....., 19....., to 8-31-44, 19.....;

that I last saw her alive on 8-31-44, 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death Immaturity

Due to 5 mo 20 d's gestation

Due to premature labor of mother

Other conditions 159
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations 159
Of autopsy 159

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 0

23. Signature Walter Riley (M. D. or other) MD
Address 4660 Maryland Date signed 8/31/44

(Licensed Embalmer's Statement on Reverse Side)

1961

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..... *Jas W. Clark*

(No Embalming)

Licensed Embalmer No. *1661*

P. O. Address *1125 Harrison St*

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.