

FILED SEP 8 1944
318

Registration District No. _____ Primary Registration District No. **11113**

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 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 23

(d) Street No. 1311a Geyer
(If rural, give location)

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

3. (a) PRINT FULL NAME Baby Halton No. 1.

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 12th
year 1944 hour 10 minute 00 P. M.

21. I hereby certify that I attended the deceased from 8/12/44
to Aug. 12th, 1944

that I last saw h. er alive on Aug. 12th, 1944
and that death occurred on the date and hour stated above.

4. Sex female 5. Color or face 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

Immediate cause of death _____
Prematurity

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

7. Birth date of deceased August 12th, 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one day 2 hr. 47 min.

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

10. Usual occupation nil

11. Industry or business ---

12. Name Frank Halton

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

14. Maiden name Eula McGraw

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) _____ (b) Date thereof 8 24 44
(Burial, ~~interment~~ removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

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

(b) Address City Hospital No. 1

19. (a) AUG 23 1944 (Date received local registrar)

J. F. Bricker (Registrar's signature)

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? _____

(Specify type of place)

While at work? _____ Means of injury 0

23. Signature 1515 Lafayette 8/14/44
(M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

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.