

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.....  
 (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 5 minutes  
 In this community 0 (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Infant Male Blackwell

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

4. Sex Male 5. Color or race Negro 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: August 1, 1944  
 (Month) (Day) (Year)

**8. AGE:** Years Months Days If less than one day  
 hr. 5 min.

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

10. Usual occupation.....

11. Industry or business.....

**MOTHER FATHER** { 12. Name William C. Blackwell

{ 13. Birthplace Pine Bluff Arkansas  
 (City, town, or county) (State or foreign country)

{ 14. Maiden name Blanche Rose

{ 15. Birthplace New Haven Missouri  
 (City, town, or county) (State or foreign country)

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

17. (a) Burial (b) Date thereof AUG 31 1944  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place burial or cremation Anatomical Dept

18. (a) Signature of funeral director W. Richter Nash  
 (b) Address 3500 Ruten Dept 7. Patt

19. (a) SEP 6 1944 (b) J. M. Breeseck  
 (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

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

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

(d) Street No. 4240a West Ashland Ave.  
 (If rural, give location)

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month August day 1st  
 year 1944 hour 9 minute 00 P.M.

21. I hereby certify that I attended the deceased from Aug 1st  
1944 to Aug 1st 1944  
 that I last saw him alive on Aug 1st  
 and that death occurred on the date and hour stated above.

Immediate cause of death subarachnoid hemorrhage

Due to.....

Due to.....

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

Major findings:  
 Of operations.....

Of autopsy subarachnoid hemorrhage

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)  
 (c) Means of injury.....

23. Signature F. W. Dickey (M. D. or other) MD  
 Address 630 S. Kingshighway Date signed 8/2/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

6892

---

---

**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.**