

XXXXX #31122
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 6 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29575

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8246

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 _____)
In this community 0
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 220
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 19 ✓
(d) Street No. 2855 Winnebago
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Baby Lyons
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 single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 13th, 1944
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 14th
year 1944 hour 1 minute 50 A.M.
21. I hereby certify that I attended the deceased from 9/13/44
1944, to Sept. 14th 1944
that I last saw him alive on Sept. 14th 1944
and that death occurred on the date and hour stated above.

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

Immediate cause of death Prematurity
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
Duration _____

9. Birthplace St. Louis City Hospital (City, town, or county) (State or foreign country) 0
10. Usual occupation nil

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name Charles
13. Birthplace Missouri (City, town, or county) (State or foreign country) 0
14. Maiden name Thelma Blank
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant M. Renard
(b) Address St. Louis City Hospital
17. (a) Cremation (b) Date thereof 9-28-44
(Month) (Day) (Year)
(c) Place: ~~burial~~ or cremation City Crematory
18. (c) Signature of funeral director W.G. White
(b) Address City Hospital NO. 1
19. (a) SEP 27 1944 (b) J. S. Brueck
(Date received local registrar) (Registrar's signature)

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 Dea Mad (M. D. or other) 9/13/44
Address 1515 Lafayette 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.