

FILED SEP 18 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 31845  
Registrar's No. 1888

Registration District No. 317

Primary Registration District No. 3069

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town R.H.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Marys Hospital  
(If not in hospital or institution, write street number or location) 0  
(d) Length of stay: In hospital or institution 1 Mo.  
(Specify whether  
In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6118 Pennsylvania Ave. 9  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Manuel B. Valdez Jr.

3. (b) If veteran, name war No 3. (c) Social Security No. 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 Aug. 12 1944  
(Month) (Day) (Year)

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

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Manuel B. Valdez Sr.

13. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Anna Reid

15. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Manuel B. Valdez Sr.

(b) Address 6118 Pennsylvania Ave.

17. (a) Burial (b) Date thereof 9-13-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope

18. (a) Signature of funeral director Joe P. Fendley, Jr. Fun. Home

(b) Address 7128 Michigan Ave.

19. (a) SEP 14 1944 (b) C. R. McCarver, MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12  
year 1944 hour 12 minute 35 P.M.

21. I hereby certify that I attended the deceased from August 12, 1944  
19\_\_\_\_ to Sept 12 1944

that I last saw him alive on Sept 12 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Patent ductus arteriosus Duration \_\_\_\_\_

Due to Congenital anomaly

Due to \_\_\_\_\_

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

Major findings: 1576  
Of operations \_\_\_\_\_

Of autopsy Patent ductus arteriosus  
Hydrocephalus

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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 Erwin T. Huber (M. D. or other) MD

Address 210 Shorter Bldg Date signed 9-13-44

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

6383

DESKOPE HOSP.  
10 AM,

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.....

*Not Embalmed*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed *Lawrence Kuchow*.....

Licensed Embalmer No. *3093*.....

P. O. Address *7178 Michigan*.....

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.