

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 1 1944
1818

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 8936

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.
(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-Max C. Starkloff
(If not in hospital or institution, write street number or location) newborn
(d) Length of stay: In hospital or institution 0 (Specify whether
In this community 0 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
Street No. 6279 FAMOUS AVE.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Baby Burgdorf

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced, single

6. (b) Name of husband or wife newborn 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 20th, 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 4 hr. _____ min.

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

10. Usual occupation nil

11. Industry or business _____

12. Name Edward

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

14. Maiden name Virginia Hawkins

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Burial (b) Date thereof Oct. 21, 1944
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Cemetery

18. (a) Signature of funeral director [Signature]
(b) Address _____

19. (a) OCT 21 1944 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20th
year 1944 hour 1:18 minute P. M.

21. I hereby certify that I attended the deceased from 10/20/44
_____ 19____ to Oct. 20th 19____
that I last saw h. ER alive on Oct. 20th 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity 5 lbs

Due to _____

Due to _____

Other conditions 157
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 [Signature] (M. D. or other) 10/20/44
Address 1515 Larayette Date signed _____

Tichenor

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.....

Not Embalmed

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

working under my personal supervision.

Signed: *J. J. Quinn*.....

..... 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.