

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 22 hours 0
(Specify whether)

In this community _____
 years, months or days

3. (a) PRINT FULL NAME Infant Female Cook

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

7. Birth date of deceased January 9, 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day hr. 22 min.

9. Birthplace St. Louis, Missouri 1
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Harold D. Cook

13. Birthplace Belleville Illinois 1
(City, town, or county) (State or foreign country)

14. Maiden name Helen C. Wallace

15. Birthplace St. Louis, Missouri 1
(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 1/13/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mathews

18. (a) Signature of funeral director Wm G. Moyall
 (b) Address 1926 Allen Ave

19. (a) JAN 13 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 237
(If outside city or town limits, write "RURAL")
 (d) Street No. 2337 Geyer Avenue
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____ 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10
 year 1945 hour 11 45 minute a M.

21. I hereby certify that I attended the deceased from Jan 9, 1945 to Jan 10, 1945
 that I last saw him alive on Jan 10, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral stroke

Due to Prematurity

Due to hydramnios & unknown cause

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

Major findings: Of operations 159

Of autopsy _____

Duration _____

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? _____

While at work? _____ (Specify type of place)
 Means of injury 0

23. Signature W. A. Toussaint (M. D. or other) _____
 Address 2720 W. Washington Date signed 1-11-45

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.

Not Embalmed

Signed.....

Wm B Moydell

Licensed Embalmer No..... 1467

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.