

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

FILED JAN 20 1945
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 St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
De Paul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify, whether

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Baby Sexauer

3. (b) If veteran, name war Nil

3. (c) Social Security No. Nil

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 11 1945
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
			<u>3</u> hr. <u>13</u> min.

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER { 12. Name Leo C. Sexauer

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

14. Maiden name Imogene Rehm

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

16. (a) Informant Imogene Sexauer

(b) Address Ste. Genevieve, Mo.

17. (a) Burial (b) Date thereof 1-14-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ste. Genevieve, Mo.

18. (a) Signature of funeral director Jerry Stanton

(b) Address Ste. Genevieve, Mo.

19. (a) JAN 12 1945 (b) J. F. Brudek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town Ste. Genevieve
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 11
year 1945 hour 3:35 minute P. M.

21. I hereby certify that I attended the deceased from Jan 11 - 1945
to Jan 11 - 1945

that I last saw her alive on Jan 11 - 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity 6 1/2 mos

Due to Cytleis in mother

Due to _____

Other conditions 15 1/2
(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) (c) Means of injury _____

23. Signature L. M. P. [unclear] (M. D. or other) _____

Address Lister Bldg. Date signed _____

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

John Ogawinski

Licensed Embalmer No.

3348

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.