

U.S. No. 2
FORM-5-43
Rev. 5-17-39
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11685

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 12 1945

Registration District No. **818**

Primary Registration District No. **1003**

Registrar's No. **3982**

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 Saint Louis Maternity Hospital **0**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 hours (Specify whether years, months or days)

In this community 7 hours (Specify whether years, months or days)

3. (a) PRINT FULL NAME Infant. Regas

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

3. (c) Social Security No. _____

4. Sex Female! 5. Color or race white

6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased April 6, 1945
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
			<u>7</u> hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Lloyd C. Regas

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

{ 14. Maiden name Freda Demmas

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

16. (a) Informant Anatomical Board

(b) Address 630 S. Kingshighway

17. (a) Anatomical Board (b) Date thereof APP 20 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director W. Richter

(b) Address 3500 Rutger

19. (a) APP 20 1945 (b) J. F. Dredsch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis **5 19**
(If outside city or town limits, write "RURAL")

(d) Street No. 4459 Laclede Avenue
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7
year _____ hour 3 minute 15 PM

21. I hereby certify that I attended the deceased from April 6 1945 to April 7 1945
that I last saw her alive on April 7 1945
and that death occurred on the date and hour stated above.

Immediate cause of death unborn

Due to Trauma of rapid delivery

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy no signs of death

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 J. P. O'Malley (M. D. or other) **MD**
Address 4932 Maryland Date signed 5/17

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

(Licensed Embalmer's Statement on Reverse Side)

5/4/45

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

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.