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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

FILED MAY 21 1945
818

Primary Registration District No. 1003

1. PLACE OF DEATH

(a) County St Louis mo
(b) City or town St Louis mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Marys Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois County 999
(c) City or town E St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2129 Kansas
(If rural, give location) N.R.
(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Baby Marciano

3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex Male 5. Color Cal race U
6. (a) Single, widowed, married, divorced U
6. (b) Name of husband or wife Baby
6. (c) Age of husband or wife 8 years
7. Birth date of deceased May 2 8 - 1945
(Month) (Day) (Year)

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

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

10. Usual occupation Child

11. Industry or business

12. Name Jefferson Derrick
13. Birthplace Huntsville Ala 9
(City, town, or county) (State or foreign country)
14. Maiden name Sally Marciano
15. Birthplace E. St Louis Ill 1
(City, town, or county) (State or foreign country)

16. (a) Informant Self
(b) Address St Louis Ill

17. (a) Removed (b) Date thereof May - 12 - 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Louis Ill

18. (a) Signature of funeral director J. F. Brebeck
(b) Address St Louis

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18th
year 1945 hour 6 minute 30 P. M.
21. I hereby certify that I attended the deceased from 5/16
to 5/18, 1945
that I last saw h. e alive on 5/16
and that death occurred on the date and hour stated above.

Immediate cause of death hemorrhage of
uterus 2 days
Due to uterus
Due to uterus
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy Multiple hemorrhage
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) (Specify type of place) (Means of injury)

23. Signature H. B. Leathers (M. D. or other) MD
Address 1421 Kansas Date signed 5/16/45

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

20
17
9

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

Jim Gaffney

Licensed Embalmer No.

3528

P. O. Address

Gettysburg Md

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.