

FILED JUL 14 1945  
318

Primary Registration District No. 1003

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: BOOTH MEMORIAL HOSP.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution ONE DAY  
(Specify whether years, months or days)  
In this community ONE DAY

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 11  
(c) City or town ST. LOUIS 123  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1224 Geyer  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARY CATHERINE LAWRENCE

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased June 30 1945  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 0 4 hr. 30 min.

9. Birthplace St Louis Mo 11  
(City, town, or county) (State or foreign country)

10. Usual occupation none INFANT

11. Industry or business \_\_\_\_\_

12. Name William Lawrence

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

14. Maiden name William Gene Parks

15. Birthplace Arkansas 1  
(City, town, or county) (State or foreign country)

16. (a) Informant William Lawrence

(b) Address 1224 Geyer

17. (a) BURIAL (b) Date thereof 7/2/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director J. H. McLaughlin

(b) Address 2301 Lafayette

19. (a) JUL 2 1945 (b) J. K. Sweeney  
(Date received locally (if any)) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30  
year 1945 hour 10 minute 30 P M.

21. I hereby certify that I attended the deceased from 6-30-1945 to 6-30-1945  
that I last saw her alive on 6-30-1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Premature birth (29 weeks old)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(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 Oley S Jones (M. D. or other) MD

Address 3616 S. Butler Date signed 6-30-45

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

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Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 L R Cooper  
Licensed Embalmer No. 3633  
P. O. Address 2317 Lafayette

**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.**