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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 3 1945

State File No. 22047

Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 6195

1. PLACE OF DEATH:

(a) County

(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: City Hospital
Max C. Starkloff Memorial 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 11
(If outside city or town limits, write "RURAL")

(d) Street No. 2849 Lyon Street 6 24
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME BABY RANDOLPH (MALE)

3. (b) If veteran, name war unknown

3. (c) Social Security No. none

4. Sex male 0

5. Color or race white

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

6. (b) Name of husband or wife - -

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

7. Birth date of deceased July (Month) 23rd (Day) 1945 (Year)

8. AGE: Years | Months | Days | If less than one day 4 hr. 27 min.

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

10. Usual occupation nile

11. Industry or business - -

FATHER
12. Name Frank
13. Birthplace (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name Mabel Crews Missouri 0
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant R. Nation

(b) Address City Hospital

17. (a) (Burial, ~~cremation or removal~~) (b) Date thereof 7-26-45 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ City Cemetery

18. (a) Signature of funeral director W. G. White

(b) Address City Hospital No. 1

19. (a) JUL 25 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1945 hour 3:50 minute A M.

21. I hereby certify that I attended the deceased from July 23, 1945 to July 24, 1945, 19 ;
that I last saw him alive on July 24, 1945, 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity Atelectasis

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature M. Hara 0 (M. D. or other)

Address 1515 Lafayette Avenue Date signed 7/24/45

(Licensed Embalmer's Statement on Reverse Side)

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.