

No. 2
1-5-43
5-17-39
I X36671

State File No. _____
Registrar's No. **6500**

FILED AUG 3 1945
Registration District No. **818**

Primary Registration District No. **1003**

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:
St. Louis City Hospital #1. 0
(If not in hospital or institution, write street number or location)

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

In this community _____
years, months or days

3. (a) PRINT FULL NAME Bahv (Male) Shreve

3. (b) If veteran, name war ---

3. (c) Social Security No. ---

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 June 29th, 1945
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
			<u>6 hr. 31 min.</u>

9. Birthplace St. Louis City Hospital #1. 0
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business _____

MOTHER FATHER

12. Name David Shreve

13. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

14. Maiden name Mary Tweddel

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital #1.

17. (a) _____ (b) Date thereof 7-26-45
(Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

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

(b) Address City Hospital #1.

19. (a) _____ (b) _____ JUL 25 1945
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 1624 Clara(rear)
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 29
year 1945 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from June 29, 1945
June 29, 1945 to June 29, 1945
that I last saw him alive on June 29, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity and atelectasis

Due to _____

Due to _____

Other conditions 159
(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 0

23. Signature George N. Darnell (M. D. or other) _____
Address 1405 Lafayette 7/2/45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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.