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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

1003

State File No. 25610

Registration District No. 318 Primary Registration District No. Registrar's No. 2551

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

**1. PLACE OF DEATH:**

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Deaconess Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community years, months or days) Infant

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County St Louis 96

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

(d) Street No. 8010 Allen NR
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Engle (Twin #1)

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race Wh.

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

6. (b) Name of husband or wife

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

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

8. AGE: Years | Months | Days | If less than one day hr. 50 min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Leroy Edwin Engle
13. Birthplace Harrisburg (City, town, or county) Penna. 1 (State or foreign country)

MOTHER
14. Maiden name Dorothy Emile Bozler
15. Birthplace St. Louis (City, town, or county) Mo. 1 (State or foreign country)

16. (a) Informant Mrs. L. E. Engle (Mother)
(b) Address 8010 Allen, St. Louis, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-45 (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director V. B. Hudson
(b) Address City Health Dept

19. (a) 8-29-45 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month August day 6
year 1945 hour 11:00 minute A. M.

21. I hereby certify that I attended the deceased from May, 1945 to Aug 6, 1945;
that I last saw him alive on Aug 6th, 1945;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to Prematurity | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

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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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Arnold S. Klein (M. D. or other) MD

Address 2632 S. Kingshighway Date signed 8/6/45

(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.**