

FILED SEP 7 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2550

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  
(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 June #2

3. (a) PRINT FULL NAME Engle (Guaranteed)

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

4. Sex male 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... 8 6 1945  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1 hr. 15 min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER  
12. Name Leroy Edwin Engle  
13. Birthplace Harrisburg Penna  
(City, town, or county) (State or foreign country)  
14. Maiden name Dorothy Emile Bogler  
15. Birthplace St. Louis Mo. A  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R. E. Engle (Mother)

(b) Address 8010 Allen St. Louis

17. (a) Burial (b) Date thereof 8-30-45  
(Burial, cremation, or removal) (City or town) (County) (State) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Y. B. Hudson

(b) Address City Health Dept

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 8010 Allen  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 6  
year 1945 hour 11:30 minute A. M.

21. I hereby certify that I attended the deceased from May  
19 45 to Aug 6 19 45  
that I last saw him alive on Aug 6  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Due to Prematurity  
Due to 159

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy.....  
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)  
(e) Means of injury 0

23. Signature Arnold K. Klein (M. D. or other) MD  
Address 2632 S. Kingshighway Date signed 8/6/45

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

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**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.**