

U.S. No. 2
DM-9-4-41
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

25946

State File No. _____

FILED AUG 24 1945
318

1003

Registration District No. _____

Primary Registration District No. _____ Registrar's No. 7029

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:
St. Ann's Hospital
(If not in hospital or institution, write street number or location)

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

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. St. Ann's Hospital
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Male: Michael

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

4. Sex M 0 5. Color or race W 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. 9 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 18 hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name _____

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

14. Maiden name Emily Michaud

15. Birthplace Soldier Point Maine
(City, town, or county) (State or foreign country)

16. (a) Informant St. Ann's Hospital
(b) Address 5301 Page Boulevard

17. (a) Burial (b) Date thereof Aug. 10-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galvery Cemetery

18. (a) Signature of funeral director Walter Walters
(b) Address 5301 Page Boulevard

19. (a) AUG 10 1945 (Date received local registrar) J. F. Bruden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 9 year 1945 hour 8 minute 35 P. M.

21. I hereby certify that I attended the deceased from Aug. 9th 1945, to Aug. 9th 1945 and that death occurred on the date and hour stated above:

Immediate cause of death Congenital Heart Disease

Due to Pre-Maturity Birth defect

Due to _____

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

Major findings: Of operations NO Of autopsy NONE

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 John B. O'Neill (M. D. or other) _____ Address 634 North Grand Date signed 8/10/45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

100
117
9

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.