

FILED OCT 31 1945

Registration District No. _____

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **newborn** (Specify whether
Life (Specify whether
In this community **Life**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** **1722**
(If outside city or town limits, write "RURAL")
(d) Street No. **1123 Frey** **9**
(If rural, give location)
(e) Citizen of foreign country? **No** **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Infant BAEW (MATE) MANNING**

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** ✓

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

alive _____ years
7. Birth date of deceased. **Aug 30 1945**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 24 hr. min.

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

10. Usual occupation **Infant**

11. Industry or business _____

MOTHER FATHER

12. Name **Edward Manning**

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

14. Maiden name **Bertha Insko**

15. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edward Manning**

(b) Address **1123 Frey**

17. (a) **Burial** (b) Date thereof **9/26/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Matthews**

18. (a) Signature of funeral director **A. W. McLaughlin**

(b) Address **2301 Lafayette Ave.**

19. (a) **SEP 25 1945** **J. F. Bredeek**
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **24th**
year **1945** hour **11:15** minute **P.** M.

21. I hereby certify that I attended the deceased from **8/30/45**
19____ to **9/24/45** 19____;
that I last saw him alive on **9/24/45** 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Diarrhea of newborn** Duration _____

Due to _____
Due to **119 a**

Other conditions: _____
(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 _____

23. Signature **M. G. Carson** (M. D.)
Address **1515 Lafayette** **9/25/45**
Date signed

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

R.P. Casper
.....
Licensed Embalmer No. *36933*

P. O. Address *337 Lafayette*

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: