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

#32034

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 21 1945 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29482

Registration District No. ..... Primary Registration District No. 1003 Registrar's No. 8007

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ooo

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1210 No. 9th St. 4
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME CHARLES ~~BABY~~ WILLEY

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

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

4. Sex Male

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 September 3rd 1945 (Month) (Day) (Year)

8. AGE: Years ..... Months ..... Days 9 If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name Azel Willey
13. Birthplace Unk. Kansas. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dorothy Toy
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Azel Willey
(b) Address 1210 N. 9th, St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-45 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave

19. (a) SEP 13 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12th year 1945 hour 5:00 minute A.M.

21. I hereby certify that I attended the deceased from 9/3/45, 19..., to 9/12/45, 19...; that I last saw him alive on 9/12/45, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Diarrhea of Newborn Atelectasis — Duration

Due to .....

Due to .....

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? (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature M. J. Carson (M. D. or other)
Address City Hospital Date signed 9-12-45

(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.

No Embalming

Signed Alfred F. Buedeker

Licensed Embalmer No. 2663

P. O. Address 5934 Alpha

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.