

FILED 05713 1945

Primary Registration District No. 6076

Registrar's No. 2338

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

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether
In this community 9 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Maryland Heights
(If outside city or town limits, write "RURAL")
(d) Street No. 101 Shumate
(If rural, give location)
(e) Citizen of foreign country? NO (Yes/No)
If yes, name country _____

3. (a) PRINT FULL NAME DRIVER, Baby Boy

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced, single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 9 26 45
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 9 hr. min.

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

10. Usual occupation None

11. Industry or business _____

12. Name Julian Driver

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

14. Maiden name Christine Strober

15. Birthplace Russellville, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mother, Christine Driver

(b) Address 101 Shumate, Maryland Hgts.

17. (a) Burial (b) Date thereof Oct. 8/45.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laurel Hill Cem.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiament Ave.

19. (a) 10-8-45 (b) E. D. M. Gorman, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 5
year 1945 hour 8 minute 20 p.m.

21. I hereby certify that I attended the deceased from 9-26 45 to 10-5 45;
that I last saw him alive on 10-5 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Congenital atresia of Esophagus
Due to Congenital Esophago-tracheal fistula
Duration 57 hr

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Same

Of autopsy Same

Duration

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) (a) Means of injury _____

23. Signature Clarence Hendon (M. D. or other) _____
Address 601 Brentwood Date signed 10-6-45

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.....

Alfred J. Boedeke

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.