V. S. No. 2
00M—5-43
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED NOV 2 1945

State File No. 31654

Registration District No. 318 Primary Registration District No. 106 Registrar's No. 9031

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: Saint Louis Maternity Hospital 0
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 317
(If outside city or town limits, write "RURAL")

(d) Street No. 6802 Smiley Ave 9
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME William Ross Avery

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 0

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased October 18, 1945
(Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day 2 hr. 5 min.

9. Birthplace St. Louis, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Harry C. Avery
13. Birthplace St. Louis Missouri 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Adele S. Saxenmeyer
15. Birthplace Red Bud Illinois 1
(City, town, or county) (State or foreign country)

16. (a) Informant Saint Louis Maternity Hospital
(b) Address 630 S. Kingshighway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 19 45
(Month) (Day) (Year)

(c) Place: burial or cremation Union Mo

18. (a) Signature of funeral director Kriegshauser
(b) Address 4228 So. Kingshighway

19. (a) OCT 19 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19
year 1945 hour 1 50 A.M. minute M.

21. I hereby certify that I attended the deceased from Oct 18 1145 P.M., 1945, to 1 50 A.M. Oct 19, 1945; that I last saw him alive on Oct 18, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Immaturity Prematurity

Due to 6½ months gestation

Due to Premature Separation of Placenta

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

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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 Melvin A. Roblee (M. D. or other)

Address 3720 Washington Date signed Oct 19

(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.....

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.