V. S. No. 2
00M—5-43
ev. 5-17-39
No. I X36671

27030
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 10 1945 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35651

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 9751

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1221 Soulard
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME BABY MONTGOMERY (MALE)

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 Oct. (Month) 7 (Day) 1945 (Year)

8. AGE: Years ---- Months 1 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

FATHER
12. Name Thomas Montgomery
13. Birthplace Patterson (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Sadie Richardson
15. Birthplace St. Louis (City, town, or county) Mo (State or foreign country)

16. (a) Informant Thomas Montgomery
(b) Address 1221 Soulard

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/45 (Month) (Day) (Year)
(c) Place: burial or cremation Patterson, Mo.

18. (a) Signature of funeral director A. W. McLaughlin
(b) Address 2301 Lafayette

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 7
year 1945 hour 5:00 minute A M.

21. I hereby certify that I attended the deceased from October 7, 1945 to November 7, 1945
that I last saw him alive on November 7, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death 1. Diarrhea due to undetermined cause
2. Prematurity
Due to _____
Due to _____
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.

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 George H. Donnell (M. D. or other)
Address 1515 Lafayette Avenue Date signed 11/7/45

(Licensed Embalmer's Statement on Reverse Side)

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

1526

1526

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 C. W. Cooper

Licensed Embalmer No. 3830

P. O. Address 230 / 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.