

FILED NOV 23 1945
Registration District No. **318**

Primary Registration District No. **1003**

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

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1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis Children's Hospital
(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

3. (a) PRINT FULL NAME Mary Kathleen Wakefield

3. (b) If veteran, name war No.

3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Infant

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

7. Birth date of deceased Oct. 26 1945
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER { 12. Name George Wakefield

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

14. Maiden name Genevieve Ferguson

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

16. (a) Informant George Wakefield

(b) Address Williamsville, Mo.

17. (a) Burial (b) Date thereof 11-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Williamsville, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) NOV 14 1945 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wayne

(c) City or town Williamsville
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November Day 11
year 1945 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from 11-2-45 19____ to 11-11 1945
that I last saw her alive on 11-11 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Atresia of Esophagus
Tracheo-Desophageal
fistula

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature K. J. Blitzer (M. D. or other) _____
Address 570 S. Kuyper Date signed _____

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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 Elmer R. Godwin
Licensed Embalmer No. 4077
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.