

2
-41
39
29484

FILED JAN 11 1945 STANDARD CERTIFICATE OF DEATH

Registration District No. **318**Primary Registration District No. **1003**

State File No.

Registrar's No. **11568**

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. Ann's Maternity Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 months
In this community 7 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Joan Yanonne

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

3. (c) Social Security No.

4. Sex F 5. Color or race W 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 May 30 1945
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
7 29 hr. min.9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)10. Usual occupation Infant

11. Industry or business.....

12. Name KKK
13. Birthplace 4
(City, town, or county) (State or foreign country)14. Maiden name Rose Yanonne
15. Birthplace Marion Illinois
(City, town, or county) (State or foreign country)16. (a) Informant St. Ann's Hospital
(b) Address 5301 Page Blvd.17. (a) Burial (b) Date thereof 12-29-45
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Calvary Cemetery18. (a) Signature of general director W. W. Walters City of St. Louis(b) Address 5301 Page19. (a) DEC 29 1945 J. F. Bredeek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. St. Ann's Hospital
5301 Page (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 29
year 1945 hour 3 A.M. minute x M.21. I hereby certify that I attended the deceased from 6-10
1945 to 12-28, 1945
that I last saw h. CK alive on 12-1, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Passing Complications
of Sepsis: Congenital
Congenital Heart
Disease

Due to.....

Due to..... 7MO

Other conditions:
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

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 Henry B. ... (M. D. or other)
Address 674 N. ... Date signed 12-29-45

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.