

**FILED AUG 9 1946**  
**318**

1003

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(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  
(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 Infant DAY

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 0

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

7. Birth date of deceased: July 14, 1946  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>2</u>	<u>4</u> hr. <u>15</u> min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Herbert James Day

13. Birthplace New York City, N Y  
(City, town, or county) (State or foreign country)

14. Maiden name Frances Meyer

15. Birthplace Webster Groves, Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Saint Louis Maternity Hosp

(b) Address 630 S. Kingshighway

17. (a) Burial (b) Date thereof 7-31-46  
(Burial, cremation, or removal) (City or town) (County) (State) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director W. Richter

(b) Address 3500 Rutger

19. (a) 7-31-46 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

Missouri 96

(a) State Missouri (b) County \_\_\_\_\_

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

(d) Street No. 118 West Bodley  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 1  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 17, 1946 day  
year \_\_\_\_\_ hour 3:30 AM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Intraaerial haemorrhage  
Premia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: Prematurity  
(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) (c) Means of injury \_\_\_\_\_

23. Signature Marianne Kubner MD D. or other) \_\_\_\_\_

Address 634 North Grand Date signed 7/26/46

**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 with the above constitutes grounds for revocation of license.)**

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