

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2147

FILED FEB 5 1947
310

Registration District No. _____

Primary Registration District No. 3058

Registrar's No. 11

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph 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 Unnamed Infant Alfred

3. (b) If veteran, name war NIL 3. (c) Social Security No. NIL
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 January 18-1947--9:10 A.M.
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day
hr. 20 min.

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

10. Usual occupation None

11. Industry or business _____

12. Name Roy Alfred
13. Birthplace St. Charles, Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Mary Jane Vogt
15. Birthplace St. Charles, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Roy Alfred
(b) Address R.R. 3 St. Charles, Mo.

17. (a) burial (b) Date thereof Jan 18-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Francis Cem. Portage des Sioux, Mo.

18. (a) Signature of funeral director H.C. Bellmeyer & Sons Co.

(b) Address 800 N. 2nd-St. Charles, Mo.

19. (a) 1-21-47 (b) James Hammett
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles
(c) City or town "Rural"
(If outside city or town limits, write "RURAL")
(d) Street No. R.R. 3 Box 168
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 18th day January
year 1947 hour 9:30 minute A. M.

21. I hereby certify that I attended the deceased from Jan 18, 1947, to Jan 18, 1947.
that I last saw him alive on Jan 18, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Subdural Hemorrhage

Due to Practically Spontaneous

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

Major findings: _____
Of operations _____

Of autopsy _____

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? _____ (c) Means of injury _____

23. Signature _____ (M. D. or other)
Address _____ Date signed 1-20-47

(Licensed Embalmer's Statement on Reverse Side)

244

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

92
9
2

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

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 2-4-47

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.