S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 3 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

2242

State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 765

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
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution premature (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. 2108 N.14th
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME BETTY BENDER

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female

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 2nd,1947.
(Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day
12 dyas hr. min.

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

10. Usual occupation nil

11. Industry or business

FATHER
12. Name John Bender
13. Birthplace Ohio
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Myrtle Wimberly
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant M.Renard
(b) Address St.Louis City Hospital

17. (a) Burial (Burial, cremation or removal) (b) Date thereof 1 23 47
(Month) (Day) (Year)

(c) Place of burial or cremation Anatomical Board ~~City Cremation~~

18. (a) Signature of funeral director W. Richter ~~W. White~~ 8500 Rutgers

(b) Address ~~City Hospital No 1~~

19. (a) 23 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 13th
year 1947 hour 1:50 minute A M.

21. I hereby certify that I attended the deceased from 1/2/47, 19, to 1/13/47, 19;
that I last saw her alive on 1/13/47, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Infant Diarrhea

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? Specify type of injury

23. Signature 1515 Lafayette 1/13/47 (M.D. or other)

Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.