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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 8 1947

#48616

Registration District No. _____

318

Primary Registration District No. 1003

Registrar's No. 2296

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: 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 newborn
(Specify whether)

In this community newborn
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 917
(If outside city or town limits, write "RURAL")

(d) Street No. 517 Withers 9
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Infant BABY HANGER #2.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 1919th
year 1947 hour 1:30 minute P M.

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 March 19th, 1947.
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to 3/19/47, 19____;

that I last saw him alive on 3/19/47, 19____;

and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
				<u>2</u> hr. <u>55</u> min.

Immediate cause of death Congenital dilatation of both lungs

Due to Prematurity - 7 months

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

Due to _____

Other conditions 1511
(Include pregnancy within 3 months of death)

10. Usual occupation _____

11. Industry or business nil

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER {

12. Name Jeff Hanger

13. Birthplace Ruble, Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Avis Lawson

15. Birthplace Ruble, Mo. 0
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Anatomical Board Date thereof 3-20-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo.

(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? 0
(If yes, specify nature of injury)

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

(b) Address 3500 Rutledge

19. (a) MAR 28 1947 (b) J. F. Brueck
(Date received local registrar) (Registrar's signature)

23. Signature 1515 Lafayette 3/19/47
Address _____ Date signed _____

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

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.