

No. 2
-12-45
-17-39
X 47070

FILED **MAY 9 1947**
#18656 318

Registration District No. _____ Primary Registration District No. **1003**

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 Memorial
(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 Law

(c) City or town St. Louis 23 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1114 Victor St.,
(If rural, give location) 90

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

3. (a) PRINT FULL NAME Infant BABY FOELSCH

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 Single

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

7. Birth date of deceased April 2nd, 1947
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2nd year 1947 hour 2:00 minute P M.

21. I hereby certify that I attended the deceased from 4/2/47 to April 2nd 1947 that I last saw him alive on April 2nd 1947 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
			<u>4 hr. 40 min.</u>

Immediate cause of death Premature Infant
Congenital Atelectasis Lung

Due to _____

Due to _____

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

10. Usual occupation nil

Other conditions 159
(Include pregnancy within 3 months of death)

11. Industry or business _____

MOTHER FATHER { 12. Name Floyd Foelsch

13. Birthplace Jacksonville, Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Mae Delaney

15. Birthplace Corning Ark.
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) _____ (b) Date of death MAY 2 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis City Hospital

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? _____

18. (a) Signature of funeral director J. F. Breakey
(b) Address _____

19. (a) MAY 2 1947 (b) _____
(Date received from Registrar) (Registrar's signature)

While at work? no (Specify type of place) _____ injury _____

23. Signature 1515 Lafayette _____ (M.D. or other) _____
Address _____ Date signed 4/2/47

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.