

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

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47070

FILED JUN 18 1947

Registration District No. **318** 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. Starbuckloff
(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 Memorial
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 4049 Washington Ave.,
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Infant BABY STEE MONSON

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 May 21st, 1947
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
			<u>17 hr. 16 min.</u>

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

10. Usual occupation _____

11. Industry or business nil

MOTHER FATHER

12. Name Archie Monson

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

14. Maiden name Bertha Wilman

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

16. (a) Informant M.A. Renard

(b) Address St. Louis City Hospital

17. (a) Anatomical Board (b) Date thereof 5-29-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director N. Rutger

(b) Address 3530 Rutger

19. (a) JUN 2 1947 (b) J. F. Breeseck
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22nd
year 1947 hour 7:55 minute A M.

21. I hereby certify that I attended the deceased from 5/21/47
0 1947 to May 22nd 1947
that I last saw her er alive on May 22nd 1947
and that death occurred on the date and hour stated above.

Immediate cause of death adrenal hemorrhage
Premature Infant, Premid death

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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? _____
Means of injury 0

23. Signature Daniel W. Hollums (M. D. or other) _____

Address 1515 Date signed _____

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.