

FILED JUN 13 1947

318

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Ann's Maternity Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution New Born
(Specify whether
In this community X
years, months or days)

3. (a) PRINT FULL NAME Joseph Relja

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased: May 27 1947
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 9 hr. 13 min.

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

10. Usual occupation New Born

11. Industry or business _____

12. Name XXXXXXXX

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

14. Maiden name Lillian Frances Relja

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

16. (a) Informant St. Ann's Maternity Hospital

(b) Address 5301 Page Boulevard

17. (a) Burial (b) Date thereof May 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Walter Walters

(b) Address 5301 Page Boulevard

19. (a) MAY 29 1947 (b) J. F. Breda
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5301 Page 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28
year 1947 hour 5 minute 27 A. M.

21. I hereby certify that I attended the deceased from New Born
5/27, 1947, to 5/27, 1947
that I last saw him alive on 5/27, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Atelectasi 10 hrs

Due to Prematurity

Due to _____

Other conditions: 15A
(Include pregnancy within 3 months of death)

Major findings: 15A
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? 0

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Jackson GTO (M. D. or other) MD
Address 5301 Page Blvd Date signed 5/28/47

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.