

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Registration District No. 317

Primary Registration District No. 3069

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town ST. LOUIS Richmond/Pls  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
ST. MARKS HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME MARY WIDMANN  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race W 6. (a) Single, widowed, married, divorced INFANT  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: MAY 22 1947  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 15 hr. \_\_\_\_\_ min.

9: Birthplace: ST. LOUIS Mo. D  
(City, town, or county) (State or foreign country)

10. Usual occupation INFANT

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name ROBERT WIDMANN  
13. Birthplace ST. LOUIS Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name ANN SKIDMORE  
15. Birthplace ST. LOUIS Mo. D  
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Widmann  
(b) Address 4915 M<sup>s</sup> Canaland

17. (a) BURIAL (b) Date thereof MAY 24-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director E. J. Schurr  
(b) Address 3125 Lafayette Ave  
19. (a) 5-26-47 (b) Paula Schurr  
(Date received local registrar) (Registrar signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County ST. LOUIS  
(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6420 CLAYTON RD.  
(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 23  
year 1947 hour 7 minute 30 A.M.  
21. I hereby certify that I attended the deceased from MAY 22  
1947 to MAY 23 1947  
that I last saw him alive on MAY 22 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis  
Due to prematurity  
Due to 159  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration 15 hrs.  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Manner of injury \_\_\_\_\_  
23. Signature Jackson (M. D. or other) MD  
Address 734 Mo Theatre Date signed 5/23/47

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

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**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..... *No Embalming* .....

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.**