

FILED OCT 24 1947
Registration District No. **318**

Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
CITY HOSPITAL #1500 LAFAYETTE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME RONNIE LEE WEST

3. (b) If veteran, name war NO 3. (c) Social Security No. 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 OCTOBER, 11 1947
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 11 hr. _____ min.

9. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name ROBERT WEST

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

14. Maiden name IRENE W. RICHMANN

15. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)

16. (a) Informant ROBERT WEST

(b) Address 2630 S. 11th ST

17. (a) BURIAL (b) Date thereof 10/13/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation VAL HALLA CEM.

18. (a) Signature of funeral director Geo. W. Clark

(b) Address 1125 HODDLE MONT AVE

19. (a) OCT 13 1947 (b) [Signature]
(Data received local registrar) (Registrar's 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. 2630 S. 11th
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 11
year 1947 hour 8 minute 10 P. M.

21. I hereby certify that I attended the deceased from October 11
1947, to Oct 11, 1947;
that I last saw him alive on Oct 11, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to _____

Due to _____

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

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) Means of injury _____

23. Signature W. J. Kennedy (M. D. or other) [Signature]

Address City of St. Louis Date signed 10-13-47

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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.....

Jos. W. Clark

Licensed Embalmer No. *1661*

P. O. Address. *1125 Hochimont au*

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.