S. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3082

FILED FEB 13 1948

Registration District No. 318

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) 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: Deaconess 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)

2. USUAL RESIDENCE OF DECEASED: 1003

(a) State Mo (b) County

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

(d) Street No. 6579 Tholozan
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Infant Sexton

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 Single

6. (b) Name of husband or wife

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

7. Birth date of deceased JAN (Month) 31 (Day) 1948 (Year)

8. AGE: Years | Months | Days | If less than one day hr. 20 min.

9. Birthplace ST. Louis (City, town, or county) Mo (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Charles Sexton
13. Birthplace Scottsville (City, town, or county) Ky (State or foreign country)

MOTHER
14. Maiden name Alida Meyer
15. Birthplace Perry County (City, town, or county) (State or foreign country)

16. (a) Informant Charles Sexton
(b) Address 6579 Tholozan

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-1948 (Month) (Day) (Year)
(c) Place: burial or cremation CONCORDIA CM.

18. (a) Signature of funeral director Rowland
(b) Address 4104 Manchester

19. (a) FEB 2 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 31
year 1948 hour 12 minute 10 M.

21. I hereby certify that I attended the deceased from Lehar pain
1-30, 19, to 1-31, 19
that I last saw b alive on , 19
and that death occurred on the date and hour stated above.

Immediate cause of death Complications Lehar

Due to ?

Due to Inability to extract head.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause of 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? (e) Means of injury

23. Signature PB Cappel m (M. D. or other) MD

Address 3284 Ivanhoe Date signed 2-2-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.....Jan M. Sizemore.....

Licensed Embalmer No.....1343.....

P. O. Address.....St Louis, Mo.....

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.