No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED FEB 9, 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3089

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 967

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

1. PLACE OF DEATH:

(a) County

(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. Starkloff (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution premature infant (Specify whether years, months or days)

In this community

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") 17

(d) Street No.: 1924 Hebert St., (If rural, give location) 9

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME: BABY GIRL SHIELDS

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: January (Month) 10th, (Day) 1948 (Year)

8. AGE: Years | Months | Days | If less than one day: 6 hr. min.

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

10. Usual occupation: nil

11. Industry or business:

FATHER — 12. Name: William Shields

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

MOTHER — 14. Maiden name: Beulah Lindsay

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

16. (a) Informant: M. Renard

(b) Address: St. Louis City Hospital

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof: JAN 31 1948 (Month) (Day) (Year)

(c) Place: burial or cremation: Anatomical Board

18. (a) Signature of funeral director: ROWLAND

(b) Address: 4104 MANCHESTER

19. (a) JAN 31 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10th year 1948 hour 7 minute A M.

21. I hereby certify that I attended the deceased from 1/10/48 19..., to Jan 10th 19 48 that I last saw her alive on Jan 10th 19 48 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Prematurity	
Birth wt 560 gms	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:
Of autopsy:

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: Daniel F. Sullivan (M. D. or other) 0

Address: 1515 Lafayette Date signed 1/10/48

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.....

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.