S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 7 1948

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14820

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 4061

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: ST. LOUIS MATERNITY HOSPITAL (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)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County 96
(c) City or town MAPLEWOOD (If outside city or town limits, write "RURAL") 5
(d) Street No. 2111 DOUGLASS (If rural, give location) 3
(e) Citizen of foreign country? (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME INFANT FEMALE YESIKENAS
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
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased APRIL (Month) 6 (Day) 48 (Year)
8. AGE: Years | Months | Days | If less than one day hr. 20 min.
9. Birthplace ST. LOUIS (City, town, or county) MISSOURI (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name PETER YESIKENAS
13. Birthplace BOSTON (City, town, or county) MASSACHUSETTS (State or foreign country)
MOTHER 14. Maiden name MILDRED DAVIDONIS
15. Birthplace WORCESTER (City, town, or county) MASSACHUSETTS (State or foreign country)
16. (a) Informant ST. LOUIS MATERNITY HOSPITAL
(b) Address 630 SO. KINGSHIGHWAY
17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof APR 30 1948 (Month) (Day) (Year)
(c) Place: burial or cremation Anatomical Board
18. (a) Signature of funeral director Rowland Mortuary Homes
(b) Address 4104 Manchester
19. (a) APR 30 1948 (Date received local registrar) (b) J. F. Medeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 6 year 48 hour 4 minute 45 A. M.
21. I hereby certify that I attended the deceased from APRIL 6 48 4:25 A.M., 19..., to April 6 48, 19 48; that I last saw her alive on April 6 48, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Intracranial hemorrhage	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Seen	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature F. P. McNally (M. D. or Coroner)
Address 3700 Washington Date signed 4/6/48

(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.