

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 12 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24486**
Registrar's No. **6730**

Registration District No. **319** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.
(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 1da (Specify whether
In this community newborn years, months or days)

3. (a) PRINT FULL NAME Baby Girl Loness

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 July 6th, 1948
(Month) (Day) (Year)

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

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

10. Usual occupation Nil

11. Industry or business _____

MOTHER, FATHER { 12. Name Truman Loness
13. Birthplace unk.
14. Maiden name Roberta Bannely
15. Birthplace unk.
(City, town, or county) (State or foreign country)

16. (a) Informant M. Renard
(b) Address St. Louis City Hospital

17. (a) Anatomical Board (b) Date thereof JUL 31 1948
(Burial, cremation, or removal)

(c) Place: burial or cremation Anatomical Board

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County no
(c) City or town 1861 Menard St. 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1861 Menard St., 9
Memorial 23 (If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7th
year 1948 hour 1 minute 05 P.M.

21. I hereby certify that I attended the deceased from July 6th
19 48 to July 7th, 19 48
that I last saw her alive on July 7th, 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia
(Neonatal death) Duration 6 hrs.

Due to _____

Due to 161 a

Other conditions 161 a
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy Atelectasis of lungs
Subtentorial hemorrhage, brain

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 V. H. Podan, M.D. (M. D. or other) _____
Address 1515 Lafayette Date signed 7-9-48

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.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug
Registrar's No. 6730

Registration District No. 318

Primary Registration District No. 1003

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:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME

Lones

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased..... July 6 (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country) Ill
14. Maiden name Roberta Bonney
15. Birthplace..... (City, town, or county) (State or foreign country) Ill

16. (a) Informant..... (b) Address.....
17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) AUG 14 1948 (Date received local registrar) (b) J. J. Budeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... year 1948 minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....

that I last saw him..... alive on....., 19..... and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....

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

Major findings:
Of operations.....
Of autopsy.....

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?.....

While at work?..... (Specify type of place) (c) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

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

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