

FEDERAL SECURITY AGENCY

75069

MISSOURI DEPARTMENT OF HEALTH

National Office of Vital Statistics

STANDARD CERTIFICATE OF DEATH

State File No.

27578

FILED AUG 28 1948

1003

Registrar's No.

7197

Registration District No. 318

Primary Registration District No.

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 Memorial
(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

3. (a) PRINT

FULL NAME

Baby Roy Carlin

3. (b) If veteran,

name war _____

3. (c) Social Security 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: August 13-1948
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation N/A

11. Industry or business _____

12. Name Douglas Carlin
13. Birthplace South Dakota
(City, town, or county) (State or foreign country)
14. Maiden name Stella Glovacki
15. Birthplace Madison, Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Douglas Carlin
(b) Address 1314 Mississippi Avenue
17. (a) Burial (b) Date thereof 8-17-1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Resurrection Cemetery

18. (a) Signature of funeral director Model
(b) Address 1926 Allen Avenue
19. (a) AUG 16 1948 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1314 Mississippi Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15
year 1948 hour 9 minute 15 A.M.
21. I hereby certify that I attended the deceased from 8-13-48
_____, 19____, to 8-15-48, 19____;
that I last saw him im alive on 8-15-48, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Respiratory Failure Duration _____

Due to Prematurity
Due to 159
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 B. Roth MD (M. D. or other) _____
Address 1515 Lafayette Avenue Date signed 8-15-48

(Licensed Embalmer's Statement on Reverse Side)

B. Roth, MD

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.....

Not Embalmed

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Benj. L. Duncan

Licensed Embalmer No. **2272**

P. O. Address **1926 Allen Avenue**

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.