

FILED AUG 28 1948

Registration District No. 1003

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 27588

7286

Registrar's 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 Children's Hospital*
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....*14 days*
(Specify whether years, months or days)

3. (a) PRINT FULL NAME.....*Christian, Sandra Sue*
(b) If veteran, name war.....*No*
(c) Social Security No.....*None*

4. Sex.....*female* 5. Color or race.....*wh.* 6. (a) Single, widowed, married, divorced.....*S*
(b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....*25 1/2* years
(Month) (Day) (Year)

7. Birth date of deceased.....*July 25 - 1943*
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 0 23 hr. min.

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

10. Usual occupation.....*Child*

11. Industry or business.....

12. Name.....*Harold W. Christian*

13. Birthplace.....*New Bloomfield, Mo.*
(City, town, or county) (State or foreign country)

14. Maiden name.....*Grace Koeppler*

15. Birthplace.....*Syracuse, Mo.*
(City, town, or county) (State or foreign country)

16. (a) Informant.....*Harold Christian*

(b) Address.....*Jefferson City, Mo.*

17. (a) Burial (b) Date thereof.....*8-20-48*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....*Jefferson City, Mo.*

18. (a) Signature of funeral director.....*Albert H. Hoppe*
(b) Address.....*4700 Washington Blvd*

19. (a) AUG 19 1948 (b) *J. B. Buech*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State.....*Missouri* (b) County.....*Cole*
(c) City or town.....*Jefferson City*
(If outside city or town limits, write "RURAL")
(d) Street No.....*Box 446*
(If rural, give location)
(e) Citizen of foreign country?.....*N.R.* (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....*August* day.....*18*
year.....*1948* hour.....*11* minute.....*A.M.*

21. I hereby certify that I attended the deceased from.....*8-4* 1948, to.....*8-18* 1948,
that I last saw him alive on.....*8-18* 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death.....*Heart Cardiac Insufficiency*
Due to.....*Congenital Heart Dis.*

Other conditions.....*157*
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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.....*Dr. J. B. Buech* (M. D. or other).....
Address..... Date signed.....

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 _____

working under my personal supervision. _____
Registered Apprentice No. _____

Signed

Gustav W. Seitel

Licensed Embalmer No.

4329

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.