

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 13 1948

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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

State File No.

Registrar's No.

27860

7686

Registration District No.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 54 34 N. Broadway
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3. (a) PRINT
FULL NAME

Infant Jett

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

8/13/48

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

5

9

hr.

min.

9. Birthplace

St. Louis City Hospital

(City, town, or county)

(State or foreign country)

10. Usual occupation

nil

11. Industry or business

12. Name

Elbert Jett

13. Birthplace

unknown

(City, town, or county)

(State or foreign country)

14. Maiden name

Mabel McGuire

15. Birthplace

Unknown

(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

AUG 31 1948

(Burial, cremation, or removal)

(Month)

(Year)

(c) Place: burial or cremation

Anatomical Board

18. (a) Signature of funeral

Rowland Mortuary Service

(b) Address

4104 Manchester Ave.

19. (a)

AUG 31 1948

(b)

J. F. Bruck

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13th
year 1948 hour 9 minute 50 A M.

21. I hereby certify that I attended the deceased from 8-13-48
....., 19....., to 8-13-48, 19.....
that I last saw him alive on 8-13-48, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure Duration

Due to prematurity

Due to.....

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 (M. D. or other)

Address 1515 Lafayette Ave Date signed 8-13-48

429

628

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.