

REC'D DEC 8 1938

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

40266  
Do not use this space.

1. PLACE OF DEATH *St. Louis County Hosp.*

(a) County *St. Louis* Registration District No. *784*

(b) Township \_\_\_\_\_ Primary Registration District No. *2*

(c) City *Clayton* (d) Street No. *C. Post* St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Deffendoll, Stillborn Baby*

(a) Residence, No. *750 Jess* St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F*

4. COLOR OR RACE *w.*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Stillborn*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov 5 1938*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Clayton Mo*

FATHER

13. NAME *Leslie Deffendoll*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ind.*

MOTHER

15. MAIDEN NAME *Esther Spengenberg*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

17. INFORMANT (ADDRESS) *Leslie Deffendoll 750 Jess Jessway Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Mt. Hope Cem* DATE *Nov 7 1938*

19. FUNERAL DIRECTOR (ADDRESS) *Funderbund Co. 7480 Prichard an*

20. FILE *1 R. Meyer M. D. D. P. H. Local Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *11/6/38*

22. I HEREBY CERTIFY, That I attended deceased from *11/6/38*, 19\_\_\_\_, to *11/6/38*, 19\_\_\_\_.

I last saw her alive on *stillborn*, 19\_\_\_\_. Death is said to have occurred on the date stated above, at *4:05A.M.*

The principal cause of death and related causes of importance were as follows:

*Monster - Deformed abnormal 9 month Infant*

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_. Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify (Signed) *M. J. Bartnick*, M. D. (Address) *St. Louis Co. Hosp.*

Date of onset *2/1/37*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHILE PRINTING, WITH UNFOLDING INK—THIS IS A PERMANENT RECORD

1 X12004

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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No. ....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No. .... or by ....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

Licensed Embalmer No. ....

**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.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

40266  
Do not use this space.

1. PLACE OF DEATH  
 (a) County St. Louis Registration District No. 784  
 (b) Township \_\_\_\_\_ Primary Registration District No. 101  
 (c) City Clayton (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Duffendell Stillborn baby  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (put in the word) Stillborn

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 6 1938

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. \_\_\_\_\_

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_

11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED 11-7 1938 T.R. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-6 1938

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. Stillborn alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) W. L. Bartnes M. D.  
 (Address) St. Louis Co. Hosp.

SUPPLEMENTAL

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

