

WRITE PAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

I X12004

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.

USE'D MAY 11 1939

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

16063
Do not use this space.

1. PLACE OF DEATH
 (a) County St. Louis Registration District No. 784
 (b) Township St. Ferdinand Clayton Primary Registration District No. 101 Registered No. 795
 (c) City Berkley Clayton (d) Street No. St. Louis Co. Hospital 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 20-0 Infant Oesch
 (a) Residence, No. Dowling Avenue. St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 30, 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 17 hrs. or 17 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. None
 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) St. Louis Co. Missouri

FATHER 13. NAME Glenn Oesch
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Co., Missouri

MOTHER 15. MAIDEN NAME Dorothy Joseph
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis. Missouri

17. INFORMANT (ADDRESS) Glenn Oesch Dowling Avenue

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE May 2, 1939

19. FUNERAL DIRECTOR (ADDRESS) Shepard Funeral Home 1167 Hamilton Avenue

20. FILED MAY - 1 1939 DR. M. J. ... Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 1, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h..... alive on _____, 19____. Death is said to have occurred on the date stated above, at 8.10AM
 The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage, due to birth injury. (Normal delivery--no forceps used)
 Other contributory causes of importance:
S. 1601 b-

Name of operation _____ Date of _____
 What test confirmed diagnosis? clinical signs an autopsy? no

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) John Howard M. D.
 (Address) Coroner of St. Louis County

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.

Not Embalmed

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.)