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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

REC'D OCT 14 1939

Registration District No. 791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30908
Primary Registration District No.
Registrar's No. 8061

1. PLACE OF DEATH: 1003
(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:
City Hospital, #1 /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri / (b) County
(c) City or town St. Louis 23
(If outside city or town limits, write "RURAL")
(d) Street No. 1718 Mississippi
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Baby Verble, Robt. Jean

3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex M.
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept. 17, 1939 (Month) (Day) (Year)

8. AGE: Years -- Months -- Days 1 If less than one day hr. min.

9. Birthplace St. Louis, Missouri 0
(City, town, or county) (State or foreign country)
10. Usual occupation Infant /
11. Industry or business 0

FATHER
12. Name Wm. Verble
13. Birthplace Illinois
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ruby Stacy
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Fannie Falkner
(b) Address 1722a Mississippi
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/39 (Month) (Day) (Year)
(c) Place: burial or cremation St. Matthews Cem
18. (a) Signature of funeral director Geo. W. McLaughlin
(b) Address 2301 Lafayette Ave
19. (a) SEP 19 1939 (Date received local registrar) (b) J. F. Broderick (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 18, year 1939 hour 12:05 minute A. M.
21. I hereby certify that I attended the deceased from September 17, 1939, to September 18, 1939 and that I last saw him alive on September 18, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Intracranial Hemorrhage

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature John F. Flynn (M. D. or other)
Address 1515 Lafayette, Date signed 9/18/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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.

Rev. 5-17-39
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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 L. P. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

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, above space should be left blank.