

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.

Registration District No. 791

Primary Registration District No. _____

State File No. _____

Registrar's No. 9313

1. PLACE OF DEATH: 7003

(a) County St. Louis

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Truandead #12 Clinton 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME: Unknown Col. male fetus

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex: male

5. Color or race: Col

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Unknown 9/20/39
French Ind (Day) (Year)

8. AGE: Years _____ Months 6 Days 22 If less than one day _____ hr. _____ min.

9. Birthplace: Franklin St. Louis, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____ 9

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: W. Murphy

(b) Address: 587 1/2 Lotus

17. (a) _____ (b) Date thereof: 10-16-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: St. Louis

18. (a) Signature of funeral director: W. A. ...

(b) Address: W. A. ...

19. (a) OCT 31 1939 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County _____

(c) City or town: Unknown
(If outside city or town limits, write "RURAL")

(d) Street No.: Unknown
(If rural, give location)

(e) If foreign born, how long in U. S. A.: _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 30
year 1939 hour 8 minute 15 A. M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;

that I last saw h. _____ alive on _____ 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death: Apparently Still Born

Due to _____

Due to: Cause Unknown

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)

Means of injury: _____

23. Signature: W. A. ... (M. D. or other) _____

Address: ...

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, above space should be left blank.