

MARGIN RESERVED FOR BINDING

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Vol 18
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF STILLBIRTH
(COMBINATION BIRTH AND DEATH CERTIFICATE)

DEC 9 - 1939

Registration District No. 784 Primary Registration District No. 106 Registrar's No. 3

1. PLACE OF STILLBIRTH:

(a) County. ST. LOUIS

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

(c) Name of hospital or institution:
256 COMMERCE
(If not in hospital or institution, give street number or location)

(d) Mother's stay before delivery in hospital or institution:
(Specify whether years, months or days)

2. USUAL RESIDENCE OF MOTHER:

(a) State. Mo.

(b) County. ST. LOUIS

(c) City or town. KIRKWOOD
(If outside city or town limits, write RURAL)

(d) Street No. 256 COMMERCE
(If rural, give location)

PRINT JAMES WALLACE CARTER

3. Full name of child

5. Sex: M. 6. Twin or triplet: No 7. Number months of pregnancy: 9

4. Date of stillbirth: 11/15/39
(Month) (Day) (Year)

8. Is mother married? yes

PRINT FATHER OF CHILD

9. Full name. JAMES PRESTON CARTER

10. Color or race. W 11. Age at time of this birth. 25 yrs.

12. Birthplace. VALLEY PARK MO
(City, town, or county) (State or foreign country)

13. Usual occupation. Florist

14. Industry or business.

PRINT MOTHER OF CHILD

15. Full maiden name. EDNA WALLACE

16. Color or race. W 17. Age at time of this birth. 16 yrs.

18. Birthplace. SCHLUTER OKLA.
(City, town, or county) (State or foreign country)

19. Usual occupation.

20. Industry or business. Housewife

21. Children born to this mother: (Not including this stillbirth)

(a) How many children of this mother are now living? none

(b) How many children were born alive but are now dead? none

(c) How many other children were born dead? none

22. Mother's usual mailing address:
256 Commerce, Kirkwood, Mo

23. Did child die before labor? yes During labor?

24. Pregnancy, complications of. none

25. Labor: (a) Complications of. none (b) Induced? no

26. (a) Was there an operation for delivery? no (Yes or No)

(b) State all operations, if any.

(c) Did child die before operation? or during operation?

27. Cause of stillbirth (state only morbid conditions causing fetal death. Do not use such terms as prematurity, asphyxia, etc.):

(a) Fetal causes. Congenital Atelectasis

(b) Maternal causes. mother treated for syphilis as child although recent test was negative

28. I hereby certify that I attended the birth of this child who was born dead at the hour of 4:45 P.M. on the date above stated.

Signature. Clara M. Seibert, M.D.
(Specify if M.D., midwife or other)

Address. Valley Park Mo

29. (a) Informant. Mrs. Edna Carter, (mother)

(b) Address. 256 Commerce, Kirkwood

30. (a) Burial, cremation, or removal. Burial (b) Date 11/17/39
(Month Day Year)

(c) Place of burial or cremation. Garden Cem

31. (a) Signature of funeral director. Kenneth W Koch

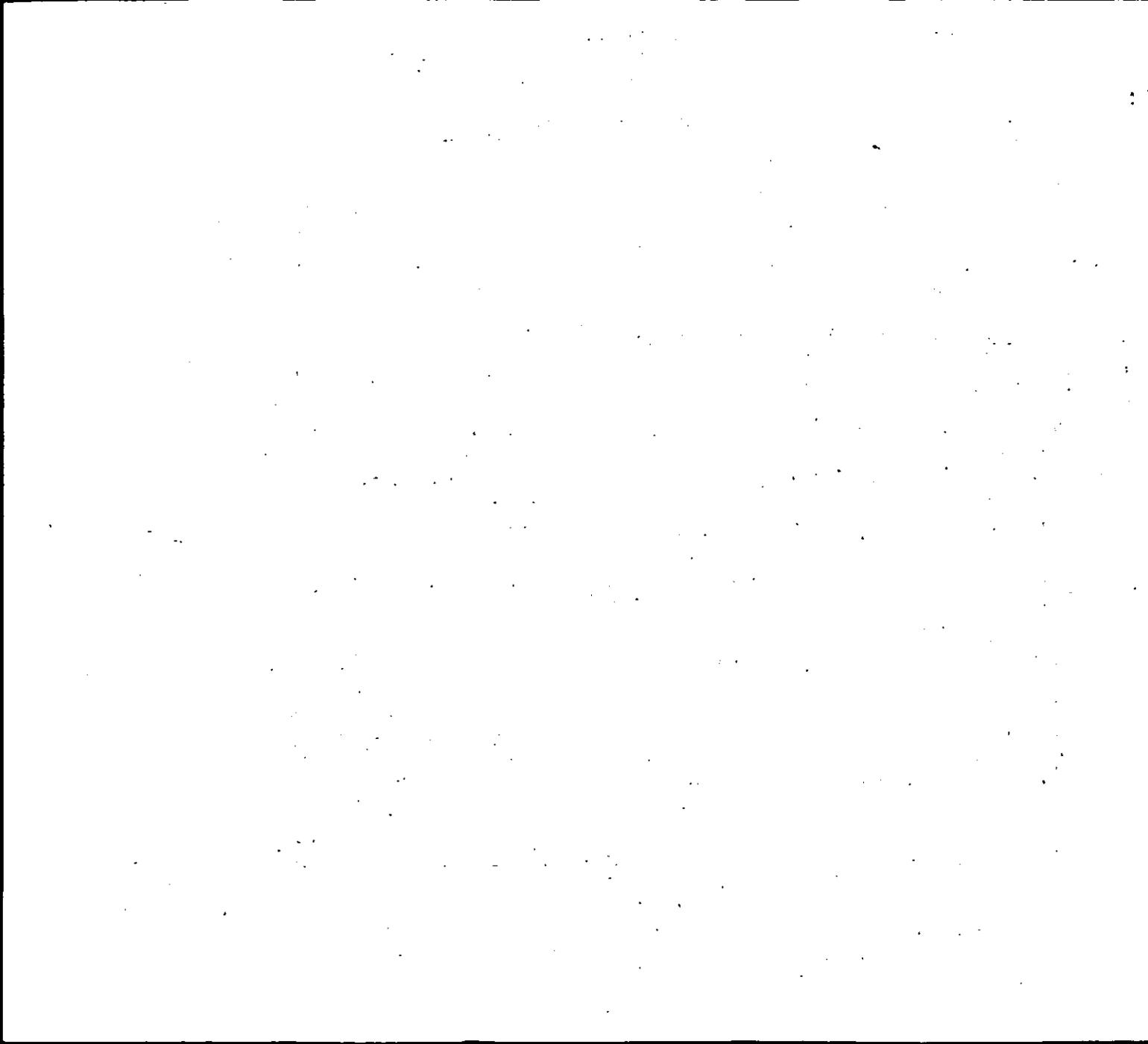
(b) Address. Benton Mo

32. (a) Statement of local registrar or coroner if physician was not present at stillbirth

(b) Signature _____ Title _____

33. Date filed with local registrar

34. Registrar's own signature. W.R. Meyer M.D. & P.V.



16 1939
 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.

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. _____

551 DEC - 1939
 Registration District No. 784

Primary Registration District No. 106

Registrar's No. 2003

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Kirkwood
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
256 S. Filmore
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution no
 In this community still born (Specify whether
 years, months or days) 636

3. (a) PRINT FULL NAME Infant of James & Edna Carter
 3. (b) If veteran, name war _____ 3. (e) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced stillborn
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Nov 15 1939
 (Month) (Day) (Year)

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

9. Birthplace Kirkwood
 (City, town, or county) (State or foreign country)

10. Usual occupation no
 11. Industry or business no

MOTHER FATHER
 { 12. Name James P. Carter
 18. Birthplace St. Louis Co.
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Edna Wallace
 15. Birthplace Oklahoma
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature James P. Carter
 (b) Address 256 S. Filmore Kirkwood Mo.

17. (a) burial (b) Date thereof Nov. 16/39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Lamkin Cemetery

18. (a) Signature of funeral director Benneth W. Koch
 (b) Address Fenton Mo.

19. (a) NOV 16 1939 (b) R. R. Meyer
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
Kirkwood
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. 256 S. Filmore
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 15th
 year 1939 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him alive on _____, 19____,
 and that death occurred on the date and hour stated above.

Immediate cause of death Atelastasis
(Congenital) Duration still born

Due to congenital defect of lungs.

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) (e) Means of injury _____

23. Signature Clara M. Schenk (M. D. or other) _____
 Address Valley Park, Mo. Date signed 11/16/39

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14

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.