

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

JAN 17 1939 701
Registration District No. **701**

Primary Registration District No. _____

1. PLACE OF DEATH: **11045**
(a) County **St. Louis Children's Hosp.**
(b) City or town _____
(c) Name of hospital or institution: **St. Louis Children's Hosp.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days**
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **David Seibert 163**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **Child**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **7-21-32**
(Month) (Day) (Year)

8. AGE: Years **7** Months **4** Days **25** If less than one day _____ hr. min.

9. Birthplace **Detroit, Ill.**
(City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business **Child**
12. Name **Fred**
13. Birthplace **Detroit, Ill. Box # 8**
(City, town, or county) (State or foreign country)
14. Maiden name **Elsie Foster**
15. Birthplace **Detroit, Ill.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **A. Blum**
(b) Address **500 S. King Highway**
17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **12/18/39**
(Month) (Day) (Year)
(c) Place: burial or cremation **Detroit, Ill.**
18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Ave.**
19. (a) **DEC 18 1939** (Date received local registrar) (b) **J. J. Budick** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **9 Piko**
(a) State _____ (b) County **Pike**
(c) City or town **Detroit, Ill. - NR**
(If outside city or town limits, write "RURAL")
(d) Street No. **Box # 8 -**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **12** day **16**
year **39** hour **1** minute **05 PM**
21. I hereby certify that I attended the deceased from **12-11-1939** to **12-16-1939**
that I last saw him alive on **12-16-1939**
and that death occurred on the date and hour stated above.
Immediate cause of death **Chronic glomerulonephritis**
Secondary Anemia
Due to _____
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) (d) Means of injury _____
23. Signature **J. J. Budick** (M. D. or other) _____
Address _____ Date signed _____

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 Guy W. Wilkinson

Licensed Embalmer No. 3575

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.