

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

44576

REGISTRATION DISTRICT No. 784

Primary Registration District No. 101

State File No. _____

Registrar's No. 2159

1. PLACE OF DEATH: St. Louis 1
 (a) County _____
 (b) City or town Clayton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis County Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution stillborn
 (Specify whether _____)
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1
 (a) State Mo. (b) County St. Louis
 (c) City or town Kinloch
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4th. between Jefferson & Wash.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

8. (a) PRINT FULL NAME Walls, Baby Girl 420
 8. (b) If veteran, name war _____
 8. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Aug. day 26
 year 1939 hour 7 minute 18 P. M.
 21. I hereby certify that I attended the deceased from 8/26/39
 _____, 19____, to 8/26/39, 19____;
 that I last saw her alive on stillborn, _____, 19____;
 and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race white
 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Aug. 26 1939
 (Month) (Day) (Year)

Immediate cause of death _____
Cremation
 Duration 8-26-39

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

Due to Signature signature of
Physician
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: _____
 Of operations _____
 Of autopsy _____

9. Birthplace Clayton Mo.
 (City, town, or county) (State or foreign country)
 10. Usual occupation nil.
 11. Industry or business _____
 MOTHER FATHER { 12. Name John Walls
 13. Birthplace ? ?
 (City, town, or county) (State or foreign country)
 14. Maiden name Cecelia Williams
 15. Birthplace ? Ill.
 (City, town, or county) (State or foreign country)

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 _____

16. (a) Informant's own signature John Walls
 (b) Address 4th & Jefferson, Kinloch, Mo.
 17. (a) Cremation (b) Date thereof 8 26 39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Pathology Dept. Hospital
 18. (a) Signature of funeral director Dr. L. C. ...
 (b) Address Clayton, Mo.
 19. (a) DEC 9 1939 (b) R. Meyer
 (Date received local registrar) (Registrar's signature)

23. Signature N. Albrecht (M. D. or other) 1
 Address St. L. Co. Mo. Date signed 8-27-39

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.