

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

1 X1051

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.

1939 DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

44577

State File No. _____

Registration District No. 784

Primary Registration District No. 101

Registrar's No. 2160

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 stillbirth.
(Specify whether _____)

In this community _____
 years, months or days)

8. (a) PRINT FULL NAME Belt, Baby Boy 430
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 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 Sept. 2 1939
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name John Belt
 13. Birthplace ? ?
(City, town, or county) (State or foreign country)

{ 14. Maiden name Isabelle Doyle
 15. Birthplace ? Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Belt

(b) Address 6400 Grand - Wellston

17. (a) Cremation (b) Date thereof 9 4 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington U. Pathology Dept.

18. (a) Signature of funeral director St. Louis Co. Hospital

(b) Address Clayton

19. (a) DEC 9 - 1939 (b) R. Mergis
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1
 (a) State Mo. (b) County St. Louis
 (c) City or town Wellston
(If outside city or town limits, write "RURAL")
 (d) Street No. 6400 Lenox.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2
 year 1939 hour 9 minute 50 P. M.
 21. I hereby certify that I attended the deceased from 9/2/39
 _____, 19____, to 9/2/39, 19____;
 that I last saw him alive on stillborn., 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Immaturity Duration 9-2-39

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 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)
 _____ (Specify means of injury)
 23. Signature R. Mergis (M. D. or other) _____
 Address St. Louis Co. Hosp 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.....

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.