

E15334

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 4477

791

1003

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 1307

1. PLACE OF DEATH: **FILED MAR 12 1940**

(a) County St. Louis, Missouri

(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital, #1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days  
(Specify whether years, months or days)

In this community 20 Years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 510 Talcott Avenue  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT 236  
FULL NAME Lillian Rose Baxter

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 25, 1887  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>8</u>	<u>12</u>	_____ hr. _____ min.

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

10. Usual occupation At home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Ashbury Babbs

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

14. Maiden name Mary Johnson

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

16. (a) Informant Ralph Baxter

(b) Address 1916 Hickory Street

17. (a) Burial (b) Date thereof 2/9/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director Math. Hermann & Son

(b) Address 2161 East Fair Avenue

19. (a) FEB 9 1940 (b) J. T. Bueck  
(Received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 6,  
year 1940 hour 9:20 minute A. M.

21. I hereby certify that I attended the deceased from February  
4, 1940, to February 6, 1940;  
that I last saw her alive on February 6, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction  
heart disease

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)  
(e) Means of injury \_\_\_\_\_

23. Signature E. R. Lewis (M. D. or other) \_\_\_\_\_  
Address 1516 Lafayette Date signed 2/6/40

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

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**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. *2967*

P. O. Address *A. P. ...*

**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.**