

Registration District No. **701**Primary Registration District No. **1003**

1. PLACE OF DEATH:

- (a) County St. Louis Mo
 (b) City or town St. Louis
 (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 6 days
 (Specify whether

In this community
years, months or days8. (a) PRINT FULL NAME NORMA JEAN WIRTH8. (b) If veteran, name war No. 8. (c) Social Security No. No.4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced6. (b) Name of husband or wife Child 6. (c) Age of husband or wife if alive7. Birth date of deceased 2-18-36
(Month) (Day) (Year)8. AGE: Years 4 Months 2 Days 15 If less than one day hr. min.9. Birthplace St. Carmel, Mo.
(City, town, or county) (State or foreign country)10. Usual occupation Child

11. Industry or business

12. Name Bernard18. Birthplace Ill.
(City, town, or county) (State or foreign country)14. Maiden name Pauline Baumgart15. Birthplace Ill.
(City, town, or county) (State or foreign country)16. (a) Informant's own signature J. F. [Signature](b) Address 500 S. [Address]17. (a) Removal (b) Date thereof 5-14-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation St. Carmel, Ill.18. (a) Signature of funeral director Albert H. Hoppe(b) Address 4700 Washington19. (a) MAY 14 1940 (b) J. F. [Signature]
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Illinois (b) County _____
 (c) City or town St. Carmel, Ill.
 (If outside city or town limits, write "RURAL")
 (d) Street No. RR # 4 NR
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13
year 40 hour 11 minute 30 p. M.21. I hereby certify that I attended the deceased from 5-7-40 to 5-13-40, 1940
that I last saw him alive on 5-13-40
and that death occurred on the date and hour stated above.Immediate cause of death Brain tumor - 3rd ventricle, malignant, unverified pathologically & Smear.
Duration _____

Due to _____

Due to _____

Other conditions 1/1/40
(Include pregnancy within 3 months of death)Major findings: ventriculo-obliteration 3rd ventricle

Of operation _____

Of autopsy Tumor of 3rd ventricle,

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)
(b) Means of injury _____23. Signature Veron [Signature] (M. D. or other) _____Address Children's Hosp Date signed 5-13-40

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. Wilkerson*

Licensed Embalmer No. 3525

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.