

1. PLACE OF DEATH:

(a) County St. Louis
(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 15 hrs. 10 min
In this community life
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Braun, Baby Girl (LST)

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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 May 4 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 15 hr. 10 min.

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

10. Usual occupation nil.

11. Industry or business _____

MOTHER FATHER { 12. Name George Braun

{ 13. Birthplace St. Louis County Mo.
(City, town, or county) (State or foreign country)

{ 14. Maiden name Lavern Bozer

{ 15. Birthplace St. Louis Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant father, George Braun
(b) Address 326 Weiss - Luxemburg

17. (a) Normal (b) Date thereof 5 13 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington U.

18. (a) Signature of funeral director W. B. ...
(b) Address _____

19. (a) MAY 16 1940 (b) Registrar's signature _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Luxemburg
(If outside city or town limits, write "RURAL")

(d) Street No. 326 Weiss
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5
year 1940 hour 2 minute 25 P. M.

21. I hereby certify that I attended the deceased from 5-4-40
_____ 19 _____ to 5-5-40 19 _____

that I last saw her alive on 5-5-40 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Starve Respiratory failure Duration _____

Due to Premature birth 15' 10"

Due to _____

Other conditions 159
(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? _____

707 While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature B. M. Passante (M. D. or other) _____

Address St. L. Co. Hosp. Date signed 5/6/40

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

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.