

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

20320

State File No.

Registrar's No.

5266

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County _____
 (b) City or town Saint Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Saint Louis Maternity Hospital /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME Brooks, Infant Boy 620

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 May 27 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 4 hr. 45 min.

9. Birthplace St. Louis, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name John Brooks /

13. Birthplace Olive Branch, Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Husmann

15. Birthplace Praxapat - Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Saint Louis Maternity Hosp

(b) Address 630 So Kingshighway Blvd

17. (a) _____ (b) Date thereof May 27 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director _____ (b) _____

19. (a) JUN 17 1940 (b) J. F. Bredeck
(Date of registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town St. Louis 19
(If outside city or town limits, write "RURAL")
 (d) Street No. 3952 Westminster Place
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27 year 1940 hour 8:30 minute A. M.

21. I hereby certify that I attended the deceased from 3:45 5/27/40
8:30 5/27 1940
 that I last saw him alive on May 27 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Haematury Duration 28 wks

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 Amie P. Kutz, M.D. (M. D. or other) _____
 Address 630 So Kingshighway Date signed 5/27/40

PLEASE PRINT FULLY 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.

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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.....

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.