

NOV 16 1940 791

1003

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

3. (a) PRINT FULL NAME Infant Girl Sucher, Joan Beth

8. (b) If veteran, name war no 8. (c) Social Security No. none

4. Sex Female 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 September 30, 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 4 hr. 30 min.

9. Birthplace Saint Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Nil.

11. Industry or business _____

12. Name Max W. Sucher

13. Birthplace Saint Louis, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Della Foley

15. Birthplace Saint Louis, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature St. Louis Maternity Hospital

(b) Address 630 S. Kingshighway Blvd.

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

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiemont Ave.

19. (a) Oct 2 1940
(Date Received local registration) J. F. [Signature]
(Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town St. Welliston
(If outside city or town limits, write "RURAL")
 (d) Street No. 1634a Lucas & Hunt Road
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 1, year 1940 hour 1 minute 45 A.M.

21. I hereby certify that I attended the deceased from September 30, 1940, to October 1, 1940, that I last saw her alive on October 1, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Perinatal Eclampsia
48 hrs gestation

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 [Signature] (M. D. or other) _____

Address 3728 Washington Date signed 10/1/40

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

Rev. 6-17-39

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.

MOTHER: FATHER:

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.....

No Embalming Body.

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.