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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37464**

DEC 11 1940
791

Primary Registration District No. **1003**

Registrar's No. **9737**

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

1. PLACE OF DEATH:

(a) County _____
(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: **St. Louis City Hospital #1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **35 Mins.**
(Specify whether _____)
In this community **35 Mins.**
years, months or days)

3. (a) PRINT FULL NAME **Baby Atkinson**

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

4. Sex **Undetermined** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Newborn**
6. (b) Name of husband or wife **Newborn** 6. (c) Age of husband or wife if alive **Newborn** years
7. Birth date of deceased **November 6, 1940**
(Month) (Day) (Year)

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

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

10. Usual occupation **Nil.**

11. Industry or business **Nil.**

12. Name **Eldred Atkinson**

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

14. Maiden name **Freta Hampton**

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

16. (a) Informant **Ann Morrison**
(b) Address **St. Louis City Hospital #1.**

17. (a) **Cremation** (b) Date thereof **11-28-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **City Crematory**

18. (a) Signature of funeral director **W. J. White**

(b) Address **City Hospital #1.**

19. (a) **NOV 27 1940** (b) _____
(Date received local final file) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **23**
(If outside city or town limits, write "RURAL")
(d) Street No. **2707 Eads Avenue**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **X** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **6**, year **1940** hour **1:00** minute _____ P. A. M.

21. I hereby certify that I attended the deceased from **November 6, 1940** to **November 6, 1940** that I last saw him **Und.** alive on **November 6, 1940** and that death occurred on the date and hour stated above.

Immediate cause of death: **Prematurity (4 mo gestation)**

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

Duration _____
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 **W. D. Hawker** (M. D. _____)
Address **1515 Lafayette Ave.** Date signed **11/25/40**

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.....

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, fact should be so stated above.