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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 24 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 33056
Registrar's No. 8009

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Anthonys Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 1/2 hours
(Specify whether
In this community life
years, months or days)

3. (a) PRINT FULL NAME Baby ARMSTRONG

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

4. Sex male
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 October 6, 1941
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 6 hr. 30 min.

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

10. Usual occupation infant

11. Industry or business _____

12. Name William Armstrong

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

14. Maiden name Helen Stasic

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

16. (a) Informant William Armstrong

(b) Address 1324 1/2 Shenandoah Ave

17. (a) burial (b) Date thereof 10-8-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Barnhart, Missouri

18. (a) Signature of funeral director W. McLaughlin

(b) Address 1930 Lafayette Ave
St. Louis

19. (a) Date received local registrar 10-7-41
(b) J. Bredich (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1324 1/2 Shenandoah Avenue
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day sixth
year 1941 hour 4 minute _____ D. M.

21. I hereby certify that I attended the deceased from Oct 4
1941 to Oct 4 1941
that I last saw him alive on Oct 4
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure

Due to Premature delivery
about 6 1/2 mos.

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 0

23. Signature A. J. Shelton (M. D. or other) M.D.
Address 4703 Virginia Date signed 10-7-41

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

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..... *Paul A. Keith*

Licensed Embalmer No. *3612*

P. O. Address..... *2317 Lafayette*

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.