. S. No. 2
OM—5-42
v. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 25 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

8893

State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2544

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 1 da (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 76

(c) City or town ~~St. Louis~~ Lemay N.R.
(If outside city or town limits, write "RURAL")

(d) Street No. ~~St. Anthony Hospital~~ 338 Hoffmeister
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Baby Pete Wallenberg -Twin #1

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 single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March (Month) 15 (Day) 1943 (Year)

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

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

10. Usual occupation none

11. Industry or business ----

FATHER
12. Name Peter Wallenberg
13. Birthplace (City, town, or county) Minnesota (State or foreign country)

MOTHER
14. Maiden name Adeline LaCrox
15. Birthplace (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Peter Wallenberg
(b) Address 338 Hoffmeister

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 3-17-43 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive

18. (a) Signature of funeral director Fendler Und. Co.
(b) Address 7420 Michigan Ave.

19. (a) MAR 1 6 1943 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from 8 30 PM to 8 45 PM
Mar. 15, 1943 to Mar. 15, 1943
that I last saw him alive on
and that death occurred on the date and hour stated above.

Immediate cause of death Fetus of 4½ months unable to maintain extra uterine life

Due to Lungs remained collapsed

Other conditions (Include pregnancy within 3 months of death) (Abruptio Placenta)

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature G. A. O'Sullivan (M. D. or other)

Address 421 W. Schermer Date signed 3/16/43

(Licensed Embalmer's Statement on Reverse Side)

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.

Not Embalmed

Signed C. E. Fendley

Licensed Embalmer No. 4148

P. O. Address St Louis

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.