

FILED FEB 1 1944

Registration District No. _____

Primary Registration District No. _____

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
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 Days
(Specify whether
 In this community 6 Days
years, months or days)

3. (a) PRINT FULL NAME Baby Ratliff

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

4. Sex Male 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 October 31, 1943
(Month) (Day) (Year)

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

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

10. Usual occupation Nil.

11. Industry or business Nil.

MOTHER FATHER

12. Name Virgil Ratliff

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

14. Maiden name Rose Mary Vessolo

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

16. (a) Informant Ann P. Morrison
St. Louis City Hospital
Max C. Starkloff Memorial

17. (a) (b) Date thereof 27-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director W. F. White

(b) Address JAN 20 1944

19. (a) (b) JAN 20 1944
(Date registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 523a Chestnut St.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 5,
 year 1943 hour 12:45 minute A. M.

21. I hereby certify that I attended the deceased from October 31, 1943 to November 5, 1943; that I last saw him alive on November 5, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity
 Due to _____
 Due to _____
 Other conditions 139
(Include pregnancy within 3 months of death)

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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) (Means of injury)

23. Signature: T. H. Dal... (M. D. or other)
 Address 1515 Lafayette Avenue Date signed 11/5/43

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

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.