

FILED MAY 2 1944

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Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 3829

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 or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
 years, months or days

3. (a) PRINT FULL NAME Infant Male Carver

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 0

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

7. Birth date of deceased April 23 23 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day hr. 55 min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Delmar L. Carver

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

14. Maiden name Lorayne LaFerriere

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

16. (a) Informant Saint Louis Maternity Hosp.
 (b) Address 630 S. Kingshighway Blvd.

17. (a) Burial (b) Date thereof 4/25/44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Math Hermann & Son
 (b) Address 2161 East Fair Ave

19. (a) APR 25 1944 (b) J. F. Mulick
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town Saint Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 3329a North 9th. Street
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23
 year 1944 hour 7 minute 35 P.M.

21. I hereby certify that I attended the deceased from April 23 1944 to April 23 1944
 that I last saw him alive on April 23 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity - Cause Indeterminate.

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy not done.

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) (c) Means of injury _____

23. Signature J. W. Piegay (M. D. or other) M.D.
 Address 630 S. Kingshighway Blvd. Date signed 4/23/44

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 *William B. Buchholz*

Licensed Embalmer No. *2110*

P. O. Address *St Louis Mo*

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.