

FILED SEP 20 1944

State File No. _____

Registrar's No. 7918

Registration District No. 318

Primary Registration District No. 1003

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

I. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: De Paul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 days
(Specify whether
In this community Since birth
years, months or days)

3. (a) PRINT FULL NAME Michael David Hanks

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

4. Sex M 0 5. Color or race W 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 Aug. 16 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 26 If less than one day _____ hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER { 12. Name XX
13. Birthplace _____
14. Maiden name Margaret Hanks
15. Birthplace Beardstown Illinois

16. (a) Informant St. Ann's Home
(b) Address Page & Union Blvds.

17. (a) Burial (b) Date thereof Sept. 15-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Walter Walters
(b) Address 5201 Page Blvd. St. Louis

19. (a) SEP 15 1944 (b) J. Bredsch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5301 Page Blvd.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. II day 11 1944
year 1944 hour 5-P. M. minute _____ M.

21. I hereby certify that I attended the deceased from Aug. 16
1944, 1944 to Sept. II, 1944
that I last saw him alive on Sept II, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Dementia Duration 6 days
Due to Alth. sprain 10 days
Seclusion 10 days
Due to Alth. sprain 10 days
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 _____

23. Signature Julius W. Bredsch (M. D. or other)
Address 6467 Union Blvd Date signed 9/12/44

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.....

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, above space should be left blank.