

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26334

FILED DEC 15 1944

Registrar's No. 10411

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME: Baby Richmond

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

4. Sex: female
5. Color or race: white
6. (a) Single, widowed, married, divorced, newborn
6. (c) Age of husband or wife if alive: --- years

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

7. Birth date of deceased: October 30th, 1944
(Month) (Day) (Year)

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

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

10. Usual occupation: nil

11. Industry or business: ---

MOTHER FATHER
12. Name: Walter
13. Birthplace: Missouri
(City, town, or county) (State or foreign country)
14. Maiden name: Katherine Sweet
15. Birthplace: Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant: M. Renard
(b) Address: St. Louis City Hospital

17. (a) (Special cremation, ~~cremation~~) (b) Date thereof: 12-7-44
(Month) (Day) (Year)
(c) Place: ~~Special cremation~~ City Crematory

18. (a) Signature of funeral director: W. J. White
(b) Address: City Hospital, 30'

19. (a) DEC 6 (b) (Date received local registrar) (Registrator's signature) Bredich

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: ^{Mac} 26/7
(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No.: 3613 No. Broadway
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country: ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Oct. day: 30th
year: 1944 hour: 9:55 minute P. M.

21. I hereby certify that I attended the deceased from 10/30/44
1944 to Oct. 30th 1944
that I last saw h. or alive on Oct. 30th 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Hydrocephalus
Spina Bifida
Due to: 157
Other conditions: Bilateral Club-feet
(Include pregnancy within 3 months of death)

Major findings: Of operations: ---
Of autopsy: Same as above.

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) ---
(2) Means of injury: ---
23. Signature: Robert E. Helt, M.D.
1515 Lafayette (Date signed) 10/31/44
Address: ---

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.