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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 5 1945

Registration District No. 318

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 39736

Registrar's No. 11145

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(b) City or town (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 (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17 6

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

(d) Street No. St Ann's Home (If rural, give location)

5301 Page blvd

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

If yes, name country

3. (a) PRINT FULL NAME Baby Janet Relja

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Fem

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 October (Month) 29 (Day) 1944 (Year)

8. AGE: Years | Months 6 mos | Days 26 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name Frances Relja
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Sister Clementine

(b) Address St. Ann's Home

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-44 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Walter Walters

(b) Address 5301 Page Blvd.

19. (a) DEC 28 1944 (Date received local registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 25th year 1944 hour 2 minute 05 A.M.

21. I hereby certify that I attended the deceased from Dec 14, 1944 to Dec 25, 1944 that I last saw her alive on Dec 25, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Atherapsia	10 days
Due to: Vomiting and diarrhea	10 days
Due to: Acute otitis med suppur.	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

119a

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 [illegible] (M. D. or other)

Address 146 [illegible] Date signed 12/25

(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 not embalmed

....., 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.