S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18514

FILED JUN 30 1945 318

Registration District No. ..... Primary Registration District No. 1003

Registrar's No. 5249

1. PLACE OF DEATH:

(a) County .....

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Overland
(If outside city or town limits, write "RURAL")

(d) Street No. 3516 St. Gregory Lane
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Infant Alsbury

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Male

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 June (Month) 13 (Day) 1945 (Year)

8. AGE: Years ..... Months ..... Days ..... If less than one day 4 hr. 29 min.

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

10. Usual occupation Infant

11. Industry or business .....

FATHER
12. Name Floyd Alsbury
13. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Irene Hartkopf
15. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Floyd Alsbury
(b) Address 3516 St. Gregory Lane

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-14-45 (Month) (Day) (Year)
(c) Place: burial or cremation Zion Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) JUN 14 1945 (Date received local registrar) J. F. Breisch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14 year 1945 hour 4:00 minute A. M.

21. I hereby certify that I attended the deceased from June 13, 1945, to June 14, 1945; that I last saw him alive on June 14, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death [illegible] (probably due to) Gastrointestinal hemorrhage

Due to [illegible]

Due to .....

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

Major findings: Of operations .....

Of autopsy .....

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? — (Specify type of place)

While at work? — (e) Means of injury .....

23. Signature [illegible] (M. D. or other) [illegible]

Address 812 [illegible] Date signed 6/14/45

(Licensed Embalmer's Statement on Reverse Side)

NO EMBALM

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.