. S. No. 2
0M—2-43
ev. 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

FILED NOV 13 1945

State File No. 35200 9602

Registration District No. Shipping Permit Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
De Paul Hospital 0
(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

(c) City or town St. Louis 12
(If outside city or town limits, write "RURAL")

(d) Street No. ~~De Paul Hospital~~ Roosevelt Hotel
(If not in city or town)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Infant Drew

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex male 0

5. Color or race white

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife ----------

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

7. Birth date of deceased November 5th 1945
(Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day 3 hr. -- min.

9. Birthplace St. Louis, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation -------

11. Industry or business

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

MOTHER
14. Maiden name Jane Drew (Connor)
15. Birthplace Indianapolis, Ind.
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Dan Drew- Father,
(b) Address Roosevelt Hotel

17. (a) Indianapolis, Ind. (b) Date thereof 11-6-45
Removal (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Indianapolis, Ind.

18. (a) Signature of funeral director Sullivan Funeral Home
(b) Address 2849 North Euclid Ave (15)

19. (a) NOV 6 1945 (b) J F Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 5th
year 1945 hour 1 minute 37 P M.

21. I hereby certify that I attended the deceased from Nov 5, 1945, to Nov 5, 1945
that I last saw him alive on Nov 5, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Atelectasis — Duration 3 hrs

Due to Prematurity

Due to

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Thomas Muir (M. D. or other) MD

Address 4500 Olive Date signed 11-5-45

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Robert F. Bunkmen

Licensed Embalmer No. 3553

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.