

FILED SEP 24 1948
 318

State File No. _____
 Registrar's No. **7806**

Registration District No. _____ Primary Registration District No. **1003**

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: **St. Louis Children's Hospital**
(If not in hospital or institution, write street number of location)
 (d) Length of stay: In hospital or institution **16 days**
(Specify whether)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **St. Louis**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1924 Hickory**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Charles Earnel Fortner**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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 **9 26 44**
(Month) (Day) (Year)

8. AGE: Years **1** Months **11** Days **12** If less than one day
 hr. _____ min. _____

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

10. Usual occupation **INFANT**

11. Industry or business
MOTHER FATHER
 12. Name **Earnel Fortner**
 13. Birthplace **Elvins Mo.**
(City, town, or county) (State or foreign country)
 14. Maiden name **Louise Hart**
 15. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **EARNEL FORTNER**
 (b) Address **1924 HICKORY**
 17. (a) **BURIAL** (b) Date thereof **9-11-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **FRONTON, MISSOURI**

18. (a) Signature of funeral director **ALBERT H. HOPPE**
 (b) Address **4700 WASHINGTON**
 19. (a) **SEP 9 1948** (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **9** day **8**
 year **46** hour **10** minute **40 P.M.**
 21. I hereby certify that I attended the deceased from **8-24**, 19**46**, to **9-8**, 19**46**
 that I last saw him **alive** on **9-8**, 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Tuberculous Meningitis Pulmonary Tuberculosis**
 Duration **1 1/2**
 Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
 Underline the cause to which death should be charged statistically.
 Major findings: _____
 Of operations _____
 Of autopsy _____

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 **R. J. Blaney** (M. D. or other) _____
 Address **St. Louis** Date signed _____

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

30564

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 *Henry M. Brammer*.....

Licensed Embalmer No. *4200*.....

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.