

No. 2  
-12-45  
-17-39  
X47070

DEPARTMENT OF COMMERCE

FILED DEC 23 1946  
# 48286

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42910

Registration District No. 314

Primary Registration District No. 1003

Registrar's No. 0873

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: St. Louis City Hospital-Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution newborn  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 18  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3332 Caroline St.,  
Memorial (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Infant RUTH SANSEGRAU

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 December 5th, 1946  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
12 hr. 15 min.

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

10. Usual occupation newborn

11. Industry or business newborn

12. Name George

13. Birthplace unknown (City, town, or county) (State or foreign country)

14. Maiden name Norma unknown

15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital.

17. (a) \_\_\_\_\_ (b) Date thereof 12-19-46  
(Month) (Day) (Year)

(c) Place: burial or cremation City Cremation

18. (a) Signature of funeral director J. W. White

(b) Address City Hospital NO. 1.

19. (a) DEC 19 1946 (Date received local registrar) J. Budrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 5th  
year 1946 hour 8:40 minute \_\_\_\_\_ P \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 12/5/46  
to Dec. 4th, 1946,  
that I last saw him im alive on Dec. 4th, 1946,  
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity Duration \_\_\_\_\_

Due to \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (b) Means of injury \_\_\_\_\_

23. Signature J. Budrick 1515 Lafayette 12/19/46 (Date signed)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

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**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.**

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

Registration District No. 318

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:  
(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)

3. (a) PRINT FULL NAME

Gansegrau

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Dec 5 1915  
(Month) (Day) (Year)

8. AGE: Years Months Days 27 12 15  
(If less than one day, hr. min.)

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

10. Usual occupation.....

11. Industry or business.....

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

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

16. (a) Informant.....  
 (b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof.....  
(Month) (Day) (Year)  
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
 (b) Address.....

19. (a) 12-19-1946 (b) J. F. Breybeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
 (c) City or town.....  
(If outside city or town limits, write "RURAL")  
 (d) Street No.....  
(If rural, give location)  
 (e) Citizen of foreign country?.....  
(Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Year 1946 hour 11 minute 15 M.

21. I hereby certify that I attended the deceased from 1915 to 1946; that I last saw him alive on 12-19-1946 and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....  
 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?.....

While at work?.....  
(Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....  
 Address..... Date signed.....

SUPPLEMENTARY

42910