

S. No. 2
-12-45
5-17-39
P 1 X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 18 1947

Registration District No. **318** Primary Registration District No. **100** Registrar's No. **172**

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri.**
(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 **1** **Premature infant**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1622** **Mississippi**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Infant BABY GROVES**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **16th**
year **1947** hour **10:00** minute **A** M.
21. I hereby certify that I attended the deceased from **5/16/47**
_____ 19____, to **May 16th** _____, 19**47**.
that I last saw her alive on **May 16th** _____, 19**47**
and that death occurred on the date and hour stated above.

4. Sex **female** / 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 **May 13th, 1947**
(Month) (Day) (Year)

Immediate cause of death **Premature birth normal death**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **1-5-47**
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? _____

8. AGE: Years _____ Months _____ Days _____ If less than one day hr. **45** min. _____

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

10. Usual occupation _____

11. Industry or business **nil**

12. Name **Unknown**

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

14. Maiden name **Elizabeth Groves**

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

16. (a) Informant **M. Renard**

(b) Address **St. Louis City Hospital**

17. (a) **Anatomical Board** Date thereof **5-22-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Louis City Hospital**

18. (a) Signature of funeral director **J. P. Budek**

(b) Address **3100 Renard**

19. (a) **JUN 2 1947** (Date received local registrar) **J. P. Budek** (Registrar's signature)

PHYSICIAN
Underline the cause to which death should be charged statistically.
23. Signature **1515 Lafayette** **5/16/47** (Specify type of place) (City or town) (County) (State)
While at work? **Suburban** (c) Means of injury _____
Date signed _____

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

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.