

Registration District No. 318

Primary Registration District No. _____

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 MATERNITY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day 1 hr. 30 min
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 96
(c) City or town CLAYTON (If outside city or town limits, write "RURAL") 2
(d) Street No. 8251 PARKSIDE DRIVE (If rural, give location) 2
NR,
(e) Citizen of foreign country? _____ (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME MALE INFANT NOTESTINE "TWIN A"

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

4. Sex MALE 5. Color or race WHITE 6. (e) Single, widowed, married, divorced _____

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

7. Birth date of deceased August 27, 1947
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 If less than one day 1 hr. 30 min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Dale J. Notestine

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

14. Maiden name Doris Muckerman

15. Birthplace Webster Groves, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Dale J. Notestine

(b) Address 8251 Parkside Dr.

17. (a) Burial (b) Date thereof 8/30/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director M.J. Croghan

(b) Address 7146 Manchester Ave

19. (a) AUG 29 1947 (b) J. F. Bralock
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 28th
year 1947 hour 10:00 minute A M.

21. I hereby certify that I attended the deceased from AUGUST 27th 19 47 to AUGUST 28th 19 47
that I last saw him alive on AUGUST 28th 19 47
and that death occurred on the date and hour stated above.

Immediate cause of death Maternal, bilateral Duration 2.5 hours

Due to Prenatal _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 1501

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 J. F. Bralock (M. D. or other) MD
Address 3720 Washington Date signed 8/29/47

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.....
not embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *B. J. Croghan*.....

Licensed Embalmer No..... *2622*.....

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.