

FILED SEP 8 1947
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **ST. LOUIS**
(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 **6 hr. 20 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** **2**
(If outside city or town limits, write "RURAL")
(d) Street No. **8251 PARKSIDE DRIVE** **3**
N.R. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) **1**
If yes, name country _____

3. (a) PRINT FULL NAME **MALE INFANT NOPESTINE, TWIN B**

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 **0**

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 _____ If less than one day **6 hr. 20 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. T. Bredeek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUGUST** day **27th**
year **1947** hour **3:00** minute _____ P.A.M.

21. I hereby certify that I attended the deceased from **AUGUST 27th** 19 **47** to **AUGUST 27, 1947**
that I last saw him alive on **AUGUST 27, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Abductor, bilateral** Duration **6 hrs.**

Due to **Prematurity**

Due to **151**

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

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 **0**

23. Signature **J. T. Bredeek** (M. D. or other) **10**
Address **3720 Washington** Date signed **8/29/47**

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
.....
working under my personal supervision.

Registered Apprentice No.....

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.