

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21302**
Registrar's No. **5836**

FILED JUL 3 1948

Registration District No. **318**

Primary Registration District No. **1003**

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. 25 min.
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Rucker, Baby Boy

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

4. Sex male 5. Color or race negro 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: June 10 1948
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 6 hr. 25 min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Rucker, John Henry
13. Birthplace Hennison Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Thomas, Maggie
15. Birthplace Princeton, Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant records of St. Louis Maternity Hospital

(b) Address 630 S. Kingshighway

17. (a) Anatomical Board (b) Date thereof JUN 30 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rowland Mortuary S.C. 410406 Manchester

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

19. (a) JUN 30 1948 (b) J. F. Prosser
(Date received local registrar) (Registrar's signature)

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. 4561 Kensington
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day tenth
year 1948 hour four minute 40 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral anoxia -
Due to atelectasis
Due to prematurity 157
Other conditions: _____
(Include pregnancy within 3 months of death)

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations _____
Of autopsy stenosis of ilium

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 Charles P. Sulich (M. D. or other) AD
Address 630 S. Kingshighway Date signed 6/11/48

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 complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.