

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

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:
Missouri Baptist Hospital 0
(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 Baby Sefafredo
3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Singles
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 18 1948
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|----------|----------|----------|-------------------------|
| | <u>0</u> | <u>0</u> | <u>0</u> | <u>9</u> hr. _____ min. |

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Leno Segafredo
13. Birthplace Klien Montana
(City, town, or county) (State or foreign country)
14. Maiden name Muriel Wottowa
15. Birthplace Coulterville Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Leno Segafredo
(b) Address 4115a West Pine

17. (a) Removal (b) Date thereof 6-19-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Coulterville, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) JUN 20 1948 (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4115a West Pine
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 18
year 1948 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from June 9 1948 to June 9 1948;
that I last saw her alive on June 9 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-respiratory failure
Due to Premature birth
About six months
Due to _____

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) (c) Means of injury _____

23. Signature J. Eversoll (M. D. or other) M.D.
Address 6356 Chyler Road Date signed 6/19/48

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

MOTHER, FATHER

1790

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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..... No. Embalm.....

..... 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.