

No. 300
-10-47
5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
100%

State File No. 28268
7504
Registrar's No.

FILED SEP 7 1948
Registration District No. 318

Primary Registration District No.

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

1. PLACE OF DEATH:
(a) County: ST. LOUIS
(b) City or town: ST. LOUIS
(c) Name of hospital or institution: JOSEPHINE HEITKAMP HOSPITAL
(d) Length of stay: In hospital or institution
In this community: years, months or days

3. (a) PRINT FULL NAME: EDWIN POWERS THEOBALD
3. (b) If veteran, name war: _____
3. (c) Social Security No.: _____

4. Sex: M. Color or race: W.
6. (a) Single, widowed, married, divorced: INFANT
6. (b) Name of husband or wife: _____
6. (c) Age of husband or wife if alive: _____ years (Day) (Year)

7. Birth date of deceased: AUGUST 26 - 1948
8. AGE: Years 0 Months 0 Days 9 hr. min.

9. Birthplace: ST. LOUIS MO. U
(City, town, or county) (State or foreign country)

10. Usual occupation: INFANT

11. Industry or business: _____

12. Name: EARL THEOBALD
13. Birthplace: ONAWA IOWA I
(City, town, or county) (State or foreign country)
14. Maiden name: MARY BEELE
15. Birthplace: CAIRO ILLINOIS I
(City, town, or county) (State or foreign country)

16. (a) Informant: Mr. Earl Theobald
(b) Address: 7226 S 10th St

17. (a) Removal (b) Date thereof: AUG. 27 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: MT. PLEASANT KY

18. (a) Signature of funeral director: E. J. Schurr
(b) Address: 3125 LA FAYETTE AV.

19. (a) AUG 27 1948 (Date received local registrar)
J. J. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State: MO (b) County: [unclear]
(c) City or town: ST. LOUIS
(d) Street No.: 1640 S. GRAND BLV.
(e) Citizen of foreign country? 17 (Yes or No)
If yes, name country: _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 8 day 26
year 1948 hour 4:00 minute P M.
21. I hereby certify that I attended the deceased from 8-26
4:00, 19 8-26-48, 19 4
that I last saw him alive on 8-26, 19 4
and that death occurred on the date and hour stated above.

Immediate cause of death: Premature Baby.
Duration: _____

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

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: Edwin Powers Theobald (M. D. or nurse)
Address: 3207 Lafayette Date signed: 8-27-48

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 *No Embalming*.....

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.