

No. 2
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-17-39
X32873

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED SEP 13 1948

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28307

Registration District No. 314

Primary Registration District No. 1103

Registrar's No. 7630

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

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **MISSOURI**..... (b) County.....
(c) City or town..... **RICHMOND HEIGHTS**
(If outside city or town limits, write "RURAL")
(d) Street No. **1124 MOORLANDS DR.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **INFANT WATERMAN**

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

4. Sex **FEMALE** / 5. Color or race **WHITE** 6. (a) 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 15 48**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
24 hr. 20 min.

9. Birthplace. **ST. LOUIS MISSOURI**
(City, town, or county) (State or foreign country)

MOTHER FATHER
12. Name **JOSEPH WILLIAM WATERMAN**
13. Birthplace **KANSAS CITY MISSOURI**
14. Maiden name **CLAIRE ADELE MEINEL**
15. Birthplace **WEBSTER GROVES MISSOURI**
(City, town, or county) (State or foreign country)

16. (a) Informant **ST. LOUIS MATERNITY HOSPITAL**
(b) Address **630 SO. KINGSHIGHWAY, CITY**

17. (a) **Anatomical Board** (b) Date thereof **AUG 31 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Anatomical Board**

18. (a) Signature of funeral director **Rowland Mortuary Ser.**

(b) Address **4104 Manchester Ave.**

19. (a) **AUG 31 1948** (b) **J.F. Braudrick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUGUST** day **16**
year **48** hour **2:50 PM** minute..... M.

21. I hereby certify that I attended the deceased from **AUGUST 15**, 19 **48**, **AUGUST 16**, 19 **48**; that I last saw **her** alive on **AUGUST 16**, 19 **48**; and that death occurred on the date and hour stated above.

Immediate cause of death.....
asphyxiation Duration **15 min**
Due to **brain damage** life
Due to **prematurity** life **Cuzo Th**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **157** PHYSICIAN

Of autopsy **This was a 6 mo premature infant.** 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 **Rochberg** (M. D. or other) **M.D.**
Address **St. Louis Maternity Hsp** Date signed **8/12/48**

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

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 comply with the above constitutes grounds for revocation of license.)

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

Sept
7630

Registration District No. *318*

Primary Registration District No. *1003*

Registrar's 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:
(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

Waterman

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced.....

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

7. Birth date of deceased..... *Aug 15* (Month) (Day) (Year)

8. AGE: Years Months Days (less than one day) hr. min.

9. Birthplace (City, town, or county) (State or foreign country) *MO*

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) *8-31-48* (b) *J. F. Bredek* (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Aug* Year *1948* hour *10* minute *15* M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

28307