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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30922

FILED SEP 24 1948 818

Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 8062

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

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. 7500 St. Charles Rock Road (If rural, give location)

(e) Citizen of foreign country? N.R. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Infant CORBETT

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

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

7. Birth date of deceased August (Month) 22 (Day) 1948 (Year)

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

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

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name John Corbett

13. Birthplace Brooklyn (City, town, or county) New York (State or foreign country)

MOTHER 14. Maiden name Beverly Lingren

15. Birthplace Rockford (City, town, or county) Illinois (State or foreign country)

16. (a) Informant John Corbett

(b) Address 7500 St. Charles Rock Road

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) SEP 14 1948 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 11th year 1948 hour 4 minute 15 A M.

21. I hereby certify that I attended the deceased from 8/22/48, 19__, to Sept. 11th, 19 48 that I last saw him alive on Sept. 11th, 19 48 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity — Duration

Diarrhea, type undetermined

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature John C. Herweg (M. D. or other)

Address 1515 Lafayette 9/11/48

(Licensed Embalmer's Statement on Reverse Side)

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.