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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 12 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

34817

State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9113

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: Evangelical Deaconess Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 day (Specify whether years, months or days) In this community: 0

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Same

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

(d) Street No.: 1222 Kraft (If rural, give location)

(e) Citizen of foreign country?: No (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: Robert Eugene Waterhouse

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Male

5. Color or race: Wh.

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: 10 (Month) - 1 (Day) - 48 (Year)

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace: St. Louis (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Marion Sylvester Waterhouse
13. Birthplace: St. Louis (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name: Edith Louisa Locke
15. Birthplace: St Louis (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: Mrs. M. Waterhouse
(b) Address: 1222 Kraft

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof: OCT 11 1948 (Month) (Day) (Year)
(c) Place: burial or cremation: Anatomical Board

18. (a) Signature of undertaker: Rowland Mortuary Service
(b) Address: 4104 Manchester Ave.

19. (a) OCT 11 1948 (Date received local registrar) (b) J. B. Lasater (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Oct. day: 3 year: 1948 hour: 1 minute: 30 a.m.

21. I hereby certify that I attended the deceased from 10/1/48, 19..., to 10/3/48, 19...; that I last saw him alive on 10/3/48, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congenital deformed heart	
Due to: Prematurity	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Operations:
Of autopsy:

PHYSICIAN — Underline the cause of 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: James D. Bell (M. D.)
Address: Deaconess Hospital Date signed: 10/6/48

Jefferson City Printing Co.

(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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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