

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 34981

Registration District No. 317

Primary Registration District No. 3069

Registrar's No. 2419

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Mary's Hosp. D  
(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)

3. (a) PRINT FULL NAME Newborn Seymour  
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 D  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct. 17, 1948  
(Month) (Day) (Year)

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

9. Birthplace Richmond Heights, Mo. D  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Robert B. Seymour  
13. Birthplace St. Louis, Missouri D  
(City, town, or county) (State or foreign country)  
14. Maiden name Dorothy Kronenberg,  
15. Birthplace St. Louis, Mo. D  
(City, town, or county) (State or foreign country)

16. (a) Informant Robert B. Seymour  
(b) Address 3736 Penrose Str.

17. (a) Burial (b) Date thereof 10/19/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director [Signature]  
(b) Address 2117 E. Grand Ave

19. (a) 10-18-48 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Adair  
(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3736 Penrose Str.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17  
year 1948 hour 6:00 minute — a.m.  
21. I hereby certify that I attended the deceased from 5:40 am  
10/17, 1948 to 10/17, 1948  
that I last saw her alive on 10/17, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Atalactasis Neonatorum Duration 20'  
Due to Prematurity (6 mo. gest.)  
Due to Placenta Previa & hemorrhage 3 hrs  
Other conditions 159  
(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 Roy V. Brediker (M. D. or other) D.M.  
Address 4500 Olive Date signed 10/17/48

Ray Boedeker

**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.

not Embalmed  
Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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