

No. 2
-12-45
5-17-39
I X47070

FILED DEC 8 1948 318
Registration District No.

Primary Registration District No. **1003**

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

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:
St. Louis Maternity Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 hour 10 min.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Infant Baby Boy Braun

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

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced 1

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

7. Birth date of deceased October 28, 1948
(Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

12. Name William Henry Braun

13. Birthplace Naylor, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Henning

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

16. (a) Informant records of St. Louis Maternity Hosp.

(b) Address 630 S. Kingshighway, St. Louis

17. (a) Anatomical Board (b) Date thereof NOV 30 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or Anatomical Board

18. (a) Signature of funeral director Roland Neal Davis

(b) Address 4104 Washington

19. (a) NOV 30 1948 (b) J. B. Lassiter
(Date of filing) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 4475 Forest Park
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 29
year 1948 hour 12:55 minute..... A. M.

21. I hereby certify that I attended the deceased from 11:45 P.M.
October 28, 1948, to 12:55 A.M. 10/29 1948;
that I last saw him alive on October 29, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
lack of development
lungs - heart -
Due to Prematurity - gestation of
16 & 17 wks
Due to Premature labor, placenta
defect.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

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 Melvin A. Roblee (M. D. or other)
Address 3720 Washington Date signed 11-1-48

Duration.....

PHYSICIAN.....

Underline the cause to which death should be charged statistically.

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.