

FILED JAN 11 1949  
**318**

**1003**

Registrar's No. **11315**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

**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 (1)  
(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 \_\_\_\_\_  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County \_\_\_\_\_

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

(d) Street No. 4246 DELMAR BLVD.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** INFANT MALE BATTLE

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

4. Sex MALE 5. Color or race NEGRO 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 DECEMBER 15 1948  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month DECEMBER day 15  
year 1948 hour 3.35P. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 11.45A.M.  
DECEMBER 15 1948 to DECEMBER 15 1948  
that I last saw h. im alive on DECEMBER 15 1948  
and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
			<u>4 hr. 50 min.</u>

Immediate cause of death Prematurity (preg. of 6 mos. duration) incompatible with life.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name FLOYD BATTLE

{ 13. Birthplace ST. LOUIS MISSOURI

{ 14. Maiden name BARBARA BATTLE

{ 15. Birthplace BOND MISSISSIPPI  
(City, town, or county) (State or foreign country)

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.

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

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

(c) Place: burial or cremation Anatomical Board

18. (e) Signature of funeral director Rowland Mortuary Service  
(b) Address 4104 Franklin

19. (a) DEC 31 1948 (b) J. B. Lasater  
(Date received local registrar) (Registrar's signature)

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)  
Means of injury \_\_\_\_\_

23. Signature John L. Coates (M. D. or other) M.D.  
Address 630 S. Kingshighway Date signed 12/17/48

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

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**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.**