

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 12 hrs. 20 min.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Baby Boy Rankin

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 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased November 27 1948
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 12 hr. 20 min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Lester Norman Rankin
13. Birthplace Little Rock Arkansas
(City, town, or county) (State or foreign country)
14. Maiden name Vivian Waller
15. Birthplace Orchardville Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Records St. Louis Maternity Hosp.
(b) Address 630 S. Kingshighway

17. (a) Anatomical Board (b) Date thereof 12-31-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director Rowland Mortuary

(b) Address 4104 Manchester

19. (a) DEC 31 1948 (b) J. B. Lasater
(Date received local registrar) (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. 4544 Meffitt
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 28
year 1948 hour 12 minute 35 A.M.

21. I hereby certify that I attended the deceased from NOVEMBER 27 12:15 P 1948 to NOVEMBER 28 1948
that I last saw him alive on NOVEMBER 28 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Asystole
Due to agenesia of Kidneys
Due to _____
Other conditions Pre-maturity Primary Atelectasis
(Include pregnancy within 5 months of death)
Major findings:
Of operations _____
Of autopsy agenesia of Kidneys

Duration

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) Means of injury _____

23. Signature John F. Critchey (M. D. or other) M.D.
Address St. Louis Maternity Date signed 1/1/49

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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.