

MINNESOTA DEPARTMENT OF HEALTH  
Division of Vital Statistics  
CERTIFICATE OF DEATH

Registered No. **23053**  
**4182 A**

1 PLACE OF DEATH: STATE OF MINNESOTA  
County **HENNEPIN**  
Township  
OR  
Village  
OR  
City **MINNEAPOLIS**  
Street Address **UNIVERSITY HOSPITALS**  
(If hospital or institution give its NAME instead of St. and No.)  
Length of stay:  
In hospital or institution yrs. mos. **1** days  
In above district yrs. mos. **1** days

2 USUAL RESIDENCE OF DECEASED:  
State **MINNESOTA**  
County **DODGE**  
Township  
OR  
Village **WEST CONCORD**  
OR  
City  
Street Address **Box 346**  
Is residence within limits of a city or an incorporated village? **500**  
(a) If veteran, name war  
(b) Social Security number, (if any):

3 FULL NAME **BABY GIRL BABCOCK**

4 SEX **FEMALE** 5 COLOR OR RACE **WHITE** 6 Single, Married, Widowed or Divorced (Write the word) **SINGLE**

7 (a) If married, widowed or divorced, NAME OF HUSBAND OR WIFE  
7 (b) AGE if alive years

8 DATE OF BIRTH (month, day, year) **9-19-47**

9 AGE Years Months Days IF LESS than 1 day, hrs. or min.  
**STILLBORN**

10 USUAL OCCUPATION **INFANT**

11 BIRTHPLACE (City or Town) (State or Country) **MINNEAPOLIS, MINNESOTA**

12 NAME **BIRDGE BABCOCK**

13 BIRTHPLACE (City or Town) (State or Country) **MINNESOTA**

14 MAIDEN NAME **JULIA RAFFERTY**

15 BIRTHPLACE (City or Town) (State or Country) **ST. PAUL MINNESOTA**

16 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant's own Signature **E. Dale Cummings (CLERK)**  
Address **TRANSCRIBED FROM HOSPITAL RECORDS**

17 Date of burial **9-22-47** Cremation: Yes  No   
Place of burial **West Concord, Minn**  
P. O. Address and State  
Name of cemetery  
Lot Number Block Number

18 Signature of Embalmer or Funeral Director: **D. M. Boyer** Emb. Lic. No. **1804**  
F. D. L. No. **793**  
Address **West Concord Minn**  
Firm name

19 Date filed: **9 22 1947** **Elin M. Holmgren**  
**DEPUTY** Signature of Local Registrar

MEDICAL CERTIFICATION

20 DATE OF DEATH **9-19-47**

21 I HEREBY CERTIFY: That I attended deceased from **9-19-47**, 19 to **9-19-47**, 19  
I last saw him **FR** <sup>dead</sup> <sub>alive</sub> on **9-19-47**, 19

To the best of my knowledge, death occurred on the date stated above, at **9:56 A.M.** M.

Immediate cause of death **Still born infant**

Due to **maternal diabetes and toxemia**

Due to  
Other conditions (Include pregnancy within 3 months of death)

Major findings Of operations:

Was autopsy performed? Major Findings:

22 If death was due to external cause, 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 **D. W. Freeman** M.D.  
Address **University Hospitals** Date **9-19-47**

WRITE PLAINLY, WITH UNFADING BLACK INK  
MARGIN PAPER FOR SUPPLYING Hospital R. 7471

Burial or removal permit issued 9-19-47 Signature of Sub-Registrar: *Elin M. Holmgren*

Abstracted Evidence Supporting Alteration.

\*Use other side if necessary.