

1. PLACE OF DEATH:

(a) County.....
(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.....
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **MISSOURI** (b) County..... **St. Louis**
(c) City or town..... **CLAYTON**
(If outside city or town limits, write "RURAL")
(d) Street No. **17 WYDOWN TERRACE**
(If rural, give location)
(e) Citizen of foreign country?.....
If yes, name country.....

3. (a) PRINT FULL NAME **Kenneth N. Rollings Jr.**

3. (b) If veteran, name war..... **No** 3. (c) Social Security No. **None**

4. Sex..... **MALE** 5. Color or race..... **WHITE**
6. (a) Single, widowed, married, divorced..... **Infant**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... **MARCH 7 48**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 15 hr. min.

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

10. Usual occupation..... **Infant**

MOTHER FATHER 11. Industry or business.....

12. Name..... **KENNETH N. ROLLINGS**
13. Birthplace..... **Athens ILLINOIS**
(City, town, or county) (State or foreign country)
14. Maiden name..... **DOROTHY RUTH HILL**
15. Birthplace..... **OAK PARK ILLINOIS**
(City, town, or county) (State or foreign country)

16. (a) Informant..... **ST. LOUIS MATERNITY HOSPITAL**
(b) Address..... **630 SO. KINGSHIGHWAY**
17. (a) **Removal** (b) Date thereof..... **3-11-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... **Athens, Ill.**

18. (a) Signature of funeral director..... **Albert H. Hoppe**
(b) Address..... **4700 Washington Blvd.**

19. (a) **MAR 11 1948** (b) **J. F. [Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **10**
year **48** hour **5** minute **35** A. M.

21. I hereby certify that I attended the deceased from **MARCH 7 2:35 PM** 19 **48** to **MARCH 10 5:35A** 19 **48**
that I last saw him alive on **MARCH 10 5:35A** 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death..... **Respiratory failure**
Due to..... **Congenital atelectasis**
Other conditions.....

Major findings:
Of operations.....

Of autopsy..... **Atelectasis bilateral**
Underline the cause of 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..... Means of injury.....
23. Signature..... **[Signature]** (M. D. or other).....
Address..... **Barneo Hospital** Date signed..... **3/10/48**

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

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

Albert G. Kapp

Licensed Embalmer No.

2971

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.