

FILED APR 8 1949
#75575

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9791

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. 1003 Registrar's No. 2944

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis City Hospital	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 1915 Senate Ave.,	

3. NAME OF DECEASED (Type or Print) BABY GIRL	a. (First)	b. (Middle)	c. (Last) BECK	4. DATE OF DEATH February 5th, 1949
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5. SEX 7.1	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH February 4th, 1949	9. AGE (In years last birthday) 15 9	10. UNDER 1 YEAR Months Days	11. UNDER 2 HRS. Hours Min. 18
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Premature	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis City Hospital	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME Ruth Beck	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME M. Renard	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		15 9 7 16	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 2/4/49, 19, to 2/5/49, 19, that I last saw the deceased alive on 2/5/49, 19, and that death occurred at 10:30 PM from the causes and on the date stated above.

23a. SIGNATURE Gerald Edgiches, M.D.	(Degree or title)	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 2/7/49
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE MAR. 31 1949	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. MAR. 31 1949	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service	ADDRESS 4104 Manchester Ave.
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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.....

....., Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

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.