No. 300
10.48

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14051

State File No. .....

BIRTH NO. 49-025378 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3881

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Missouri
c. LENGTH OF STAY (In this place): ( )

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MISSOURI BAPTIST HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: ...
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 5233a Wren Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Judith
b. (Middle): Ann
c. (Last): Patruso

4. DATE OF DEATH (Month) (Day) (Year): 4-3-49

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): ( )

8. DATE OF BIRTH: 4-1-49

9. AGE (In years last birthday): If under 1 year: Months / Days 2; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): (0)

12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: Anthony C. Patruso

13b. MOTHER'S MAIDEN NAME: Madeline Grace Frintray

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mrs. A.C. Patruso -5233a Wren Aven

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

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) Period of Gestation (20 wk)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

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): 139

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?: 7760

22. *I hereby certify that I attended the deceased from* 4/1, 1949, *to* 4/3, 1949, *that I last saw the deceased alive on* 4/2, 1949, *and that death occurred at* 7:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Charles [illegible] Harris M.D.

23b. ADDRESS: 5298a Page.

23c. DATE SIGNED: 4/3/49

24a. BURIAL, CREMATION, REMOVAL (Specify):

24b. DATE: APR 30 1949

24c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

24d. LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG.: APR 30 1949

REGISTRAR'S SIGNATURE: J. B. Lasater

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rowland Mortuary Service
4164 Manchester Ave.

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Student Embalmer No. .....,

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

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.