

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 14184

BIRTH NO. 49-019463 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3880

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 <u>Mo</u> b. COUNTY <u>Mo</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo</u>		c. LENGTH OF STAY (In this place) <u>17</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis - Mo</u>		d. STREET ADDRESS (If rural, give location) <u>5189 Vernon Ave</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Christian Hospital</u>				3. NAME OF DECEASED a. (First) <u>Baby</u> b. (Middle) <u>Infant</u> c. (Last) <u>Sodko</u>			
4. DATE OF DEATH <u>3-23-1949</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	
8. DATE OF BIRTH <u>3-19-1949</u>		9. AGE (In years last birthday) <u>4</u>		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <u>Catherine Ann Sodko</u>		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 <u>Catherine Ann Sodko</u> ADDRESS <u>5189 Vernon Ave</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Premature Birth</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>?</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>6 mo gestation</u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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) <u>15th</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>776X</u>				22. I hereby certify that I attended the deceased from <u>March 19, 1949</u> , to <u>March 23, 1949</u> , that I last saw the deceased alive on <u>March 23, 1949</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>J. Phyllis D. G. D.</u> (Degree or title)		23b. ADDRESS <u>602 N Grand</u>		23c. DATE SIGNED <u>3-30-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>APR 30 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>APR 30 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Lassiter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland S. Mortuary Service</u> 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.