

20787

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

5999

FILED JUL 15 1949

BIRTH NO. 496354-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE 1740 S 18 Street b. COUNTY St Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1740 S 18 Street		d. STREET ADDRESS (If rural, give location) 1740 S 18 Street	
3. NAME OF DECEASED (Type or Print) a. (First) Infant b. (Middle) Blank c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 7 - 7 - 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) N11	8. DATE OF BIRTH July 7 1949
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N11		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 2, 20
11. BIRTHPLACE (State or foreign country) St Louis		12. CITIZEN OF WHAT COUNTRY? 0	
13a. FATHER'S NAME Granville Blanke		13b. MOTHER'S MAIDEN NAME Virginia Musgrove	
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 Granville Blanke	
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.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Immature infant</i> ANTECEDENT CAUSES DUE TO (b) <i>unknown</i> DUE TO (c) <i>unknown</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>unknown</i>	
18. INTERVAL BETWEEN ONSET AND DEATH		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) 159		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? 77 BX	
22. I hereby certify that I attended the deceased from <i>July 7, 1949</i> , to <i>July 7, 1949</i> , that I last saw the deceased alive on <i>July 7, 1949</i> , and that death occurred at <i>7:00 p. m.</i> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <i>Bernard W. Gerwitz, M.D.</i>		23b. ADDRESS <i>508 W. Grand</i>	
23c. DATE SIGNED <i>7/8/49</i>		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE <i>7/8/49</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Sunset Burial Park</i>	
24d. LOCATION (City, town, or county) (State) <i>St Louis</i>		DATE REC'D BY LOCAL REG. <i>Jul 9 1949</i>	
REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	
ADDRESS <i>1926 Allen Av</i>			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10.48

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 _____

not Embalmed

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.