

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 24766
6270

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|---|--|--|--|--|--|--|--|
| BIRTH NO. <u>44648-48</u> | | REG. DIST. NO. | | PRIMARY REG. DIST. NO. | | Registry's No. | |
| 1. PLACE OF DEATH a. COUNTY <u>Missouri</u> b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis, Mo.</u> c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION <u>De Paul Hosp.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u> d. STREET ADDRESS (If rural, give location) <u>17-2903a Victor St.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Infant</u> b. (Middle) <u>Eshbaugh</u> c. (Last) <u>17</u> | | 4. DATE OF DEATH (Month) <u>6</u> (Day) <u>18</u> (Year) <u>1949</u> | | 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u> | | 8. DATE OF BIRTH <u>July 14 1949</u> | | 9. AGE (In years last birthday) <u>3</u> IF UNDER 1 YEAR Months <u>3</u> IF UNDER 24 HRS. Days <u>3</u> Hours <u>3</u> Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? | | 13a. FATHER'S NAME <u>Mr. Walter Eshbaugh</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Mrs. Adalyn Eshbaugh</u> | | 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Walter Eshbaugh</u> | | ADDRESS | | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cryptosporidiosis Fetalis</u> *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Maternal R.H. sensitivity</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION <u>None</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>None done</u> | | 20. AUTOPSY? YES <input 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) <u>16th</u> | | 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? <u>7700</u> | | 22. I hereby certify that I attended the deceased from <u>7/14, 1949</u> to <u>7/18, 1949</u> , that I last saw the deceased alive on <u>7/14, 1949</u> , and that death occurred at <u>6:00 PM.</u> , from the causes and on the date stated above. | | | | 23a. SIGNATURE (Degree or title) <u>Deborah Collins M.D.</u> | |
| 23b. ADDRESS <u>2301 N. Kingshighway</u> | | 23c. DATE SIGNED <u>7/19/49</u> | | 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>7/18/49</u> | |
| 24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u> | | 24d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Sullivan Bros.</u> | | ADDRESS <u>2849 N. Euclid</u> | |
| DATE REC'D BY LOCAL REG. <u>JUL 19 1949</u> | | REGISTRAR'S SIGNATURE <u>J. B. Foster</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |

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

Dr. Collins
1200 N. W. 10th Ave
No. 3735

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 _____

working under my personal supervision.

Student Embalmer No.

Signed

Robert L. Brinkman

Signed.....
Student Embalmer

Licensed Embalmer No. 3553

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.