

No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25532

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

FILED AUG 2 1949

BIRTH NO. 46632-49 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069 Registrar's No. 1802

1. PLACE OF DEATH a. COUNTY <i>St. Louis Richmond Heights</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Missouri</i> b. COUNTY <i>St. Louis</i>	
b. CITY OR TOWN <i>Richmond Heights</i>		c. CITY OR TOWN <i>St. Louis</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Mary's Hospital</i>		d. STREET ADDRESS (If rural, give location) <i>6216 Arandes Drive</i>	

3. NAME OF DECEASED (Type or Print) a. (First) <i>Michael</i> b. (Middle) <i>Stephen</i> c. (Last) <i>Savage</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>7 3 49</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>7/11/49</i>	9. AGE (In years last birthday)	10. UNDER 1 YEAR Days <i>2</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Missouri</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					

13a. FATHER'S NAME <i>Justin H. Savage</i>	13b. MOTHER'S MAIDEN NAME <i>Mildred Pryor</i>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT'S SIGNATURE OR NAME <i>Justin H. Savage</i>	ADDRESS <i>6216 Arandes</i>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Prematurity, 30 wks gestation</i>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) <i>associated with</i>		
	DUE TO (c) <i>General metabolic failure</i>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	(20) AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i> (Degree or title) <i>M.D.</i>	23b. ADDRESS <i>634 N. Grand</i>	23c. DATE SIGNED <i>7-4-49</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>7/5/49</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Calloway</i>	24d. LOCATION (City, town, or county) (State) <i>St. Louis</i>
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DATE REC'D BY LOCAL REG. <i>7-5-49</i>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS <i>Southern Funeral Home</i>
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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.

Signed _____ *NOT Embalmed*

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.