

FILED SEP 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31670**
7901

BIRTH NO. _____ 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)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE MISSOURI b. COUNTY MO	
c. LENGTH OF STAY (in this place) WIFE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis Childrens Hospital		d. STREET ADDRESS (If rural, give location) 811 1/2 Russell Bl.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Ralph	b. (Middle) Edward	c. (Last) Choate	9-10-49		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S	8. DATE OF BIRTH Dec. 26-1941		9. AGE (In years last birthday) 7 MONTHS 8 DAYS 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Elementary School		11. BIRTHPLACE (State or foreign country) St. Louis, MISSOURI	
13a. FATHER'S NAME Owen Choate			13b. MOTHER'S MAIDEN NAME Lucille Minney		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 Owen Choate 811 1/2 Russell Bl.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tetralogy of Fallot		ANTECEDENT CAUSES Atelectasis of Right + left upper lobe of the lungs		7 1/2 yrs	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) of the lungs		2 days	
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 9-8-49		19b. MAJOR FINDINGS OF OPERATION Tetralogy of Fallot		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) St. Louis MO	
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? fall	

22. I hereby certify that I attended the deceased from **Sept 6, 1949**, to **Sept 10, 1949**, that I last saw the deceased alive on **Sept 10, 1949**, and that death occurred at **2:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Wm. A. King		(Degree or title) MD		23b. ADDRESS 500 S. Kingshighway		23c. DATE SIGNED 9-10-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-13-49		24c. NAME OF CEMETERY OR CREMATORY Mount Hope		24d. LOCATION (City, town, or county) (State) St. Louis County MO.	

DATE RECD BY LOCAL REG. SEP 12 1949		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. McLaughlin 230 Lafayette	
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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.

Student
Student Embalmer

Signed.....

D W Cooper

Licensed Embalmer No. *38/30*

P. O. Address *2301 Kufayeh*

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.