

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **31931**
8403
Registrar's No. _____

BIRTH NO. 101232 61054-49		REG. DIST. NO. 318		PRIMARY REG. DIST. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place) 7		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.				d. STREET ADDRESS (If rural, give location) 25-1453 Blair Ave.,			
3. NAME OF DECEASED (Type or Print) a. (First) Baby b. (Middle) Girl c. (Last) Leady #1.			4. DATE OF DEATH (Month) (Day) (Year) Sept. 18th, 1949				
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single //		8. DATE OF BIRTH 9/16/49	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) premature infant		11. BIRTHPLACE (State or foreign country) St. Louis City Hospital D		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME John Blair		13b. MOTHER'S MAIDEN NAME Barbara Collins		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			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) (STATE) 159			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 776X			
22. I hereby certify that I attended the deceased from 9/16/49 to 9/18/49 , 19____, that I last saw the deceased alive on 9/18/49 , 19____, and that death occurred at 4:15am on 19 ____, from the causes and on the date stated above.							
23a. SIGNATURE J W Banning, M.D.				23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 9/19/49	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE SEP 30 1949		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. SEP 30 1949		REGISTRAR'S SIGNATURE J B Sauter		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service Inc. 4104 Manchester Ave. St. Louis 10, Mo.			

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:

..... 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.