

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31955

State File No. ....

FILED OCT 7 1949

BIRTH NO. 61101-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8387

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (If deceased lived. If institution: residence before admission.) a. STATE <b>ILLINOIS</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>EAST ST. LOUIS</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>ST. LOUIS MATERNITY HOSPITAL</b>		d. STREET ADDRESS (If rural, give location) <b>725 NO. 1st. ST.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Infant</b> b. (Middle) c. (Last) <b>LOVING</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>SEPTEMBER 21 49</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH <b>SEPTEMBER 21 49</b>		9. AGE (In years last birthday)		10. F UNDER 1 YEAR 11. F UNDER 10 YRS. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ST. LOUIS MISSOURI</b>	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME <b>CULLEN JESSIE LOVING</b>		13b. MOTHER'S MAIDEN NAME <b>JOSEPHINE WEATHERS HENDERSON</b>		14. NAME OF HUSBAND OR WIFE	
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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 <b>ST. LOUIS MATERNITY HOSPITAL</b>	
				ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>	
<p>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Premature Birth</b>					
		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.					

19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION <b>None</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>None</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St. Louis Missouri</b>	
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? <b>776X</b>	

22. I hereby certify that I attended the deceased from Sept 21, 19 49, to Sept 21, 19 49, that I last saw the deceased alive on Sept 21, 19 49, and that death occurred at 3:25 Am., from the causes and on the date stated above.

23a. SIGNATURE <b>Arthur G. Santorino</b>		(Degree or title) <b>M.D.</b>		23b. ADDRESS <b>St. Louis Maternity Hosp</b>		23c. DATE SIGNED <b>9-21-49</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Autonomous Burial</b>		24b. DATE <b>9-30-49</b>		24c. NAME OF SEMETERY OR CREMATORY <b>Anatomical Bldg</b>		24d. LOCATION (City, town, or county) (State)	
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DATE REC'D BY LOCAL HEALTH OFFICER <b>SEP 30 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Sasser</b>		FUNERAL DIRECTOR'S SIGNATURE <b>Howland Service - 4104 Washington</b>		ADDRESS	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

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.