

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42718

State File No.

FILED JAN 7 1950

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11147**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Springfield	
c. LENGTH OF STAY (in this place) 27 days		d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Childrens	
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Wilson c. (Last) Lybyer		4. DATE OF DEATH (Month) (Day) (Year) 12 24 49	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 2-11-48
9. AGE (In years last birthday) 10		IF UNDER 1 YEAR Months 13	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Never Married	11. BIRTHPLACE (State or foreign country) Springfield, Mo
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Albert L. Lybyer	
13b. MOTHER'S MAIDEN NAME Joan Wilson		14. NAME OF HUSBAND OR WIFE Never Married	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Albert Lybyer		ADDRESS Springfield, Missouri	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital heart disease - non-functioning right ventricle, tricuspid atresia. 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 12-25-49		19b. MAJOR FINDINGS OF OPERATION Same as 18. I. (a)	
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) 157	
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? 7544			
22. I hereby certify that I attended the deceased from 11-28 , 19 49 , to 12-24 , 19 49 , that I last saw the deceased alive on 12-24 , 19 49 , and that death occurred at 12:20 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE Wm G. Klingberg MD		23b. ADDRESS St. Louis Childrens Hosp.	
23c. DATE SIGNED 12-24-49		23d. LOCATION (City, town, or county) (State) Houston, Missouri	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-24-49	
24c. NAME OF CEMETERY OR CREMATORY City		24d. LOCATION (City, town, or county) (State) Houston, Missouri	
DATE REC'D BY LOCAL REG. DEC 27 1949		REGISTRAR'S SIGNATURE J. B. Foster	
25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington	

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~~ Me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Geo W Wilkinson

Licensed Embalmer No. 3575

P. O. Address St Louis Mo

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.