

FILED JAN 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43929

State File No.

No. 300

10-48

#101540

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 11336

BIRTH NO. <u>83957-49</u>		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>11336</u>			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u>				b. COUNTY <u>1114</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) <u>4105 Gano Ave.,</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Hospital</u>				10					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Baby</u>			b. (Middle) <u>Girl</u>		c. (Last) <u>McMurrey</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12/22/49</u>		
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>		8. DATE OF BIRTH <u>12/22/49</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months Days IF UNDER 14 HRS. Hours Min. <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nil</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>St. Louis City Hospital</u>			12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>Dr. S.I. McMurrey</u>			13b. MOTHER'S MAIDEN NAME <u>Eve Massey</u>			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 <u>M. Renard, St. Louis City Hospital #1.</u>				
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>[REDACTED]</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Hydrops fetalis (Erythroblastosis fetalis)</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>						INTERVAL BETWEEN ONSET AND DEATH	
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) <u>7700</u>					
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?					
22. I hereby certify that I attended the deceased from <u>12/22/49</u> to <u>12/22/49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>12/22/49</u> , 19 <u>49</u> , and that death occurred at <u>11:25 pm</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>[Signature]</u>				23b. ADDRESS <u>1515 Lafayette Ave.,</u>			23c. DATE SIGNED <u>1/6/50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>6</u>		24b. DATE <u>JAN 18 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>			
DATE REC'D BY LOCAL <u>JAN 18 1950</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rowland Mortuary Svc. 4104-06</u>				

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

(Licensed Embalmer's Statement on Reverse Side)

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.