

THE DIVISION OF HEALTH OF MISSOURI
FILED MAY 1 1950 STANDARD CERTIFICATE OF DEATH

15058
State File No. 15058
3660
Registrar's No. 3660

BIRTH NO. 21592-50 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2064	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 1363 Blackstone 0	

3. NAME OF DECEASED (Type or Print) Baby Infant Tanner # 1			4. DATE OF DEATH (Month) (Day) (Year) 4-19-50		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 4-19-50	9. AGE (In years last birthday)	# UNDER 1 YEAR Months 4 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME William Tanner		13b. MOTHER'S MAIDEN NAME Betty Helmering		14. NAME OF HUSBAND OR WIFE Never Married	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Tanner 1363 Blackstone	

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Respiratory failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 hrs.</i>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Unwickability due to delivery at 6 mos</i>		
	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	19b. MAJOR FINDINGS OF OPERATION <i>No operation</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	

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? <i>7735</i>
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22. I hereby certify that I attended the deceased from *4-19-1950* to *4-19-1950*, that I last saw the deceased alive on *4/19*, 1950, and that death occurred at *8:50a* m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Henry J. O'Jingo M.D.</i>		23b. ADDRESS Missouri Theatre Bldg.	23c. DATE SIGNED 4-20-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-20-50	24c. NAME OF CEMETERY OR CREMATORY Steelville Cemetery	24d. LOCATION (City, town, or county) (State) Steelville, Missouri

DATE REC'D BY LOCAL HEALTH DEPT. APR 21 1950	REGISTRAR'S SIGNATURE <i>J. B. Sasser</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Handwritten signature

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 _____

working under my personal supervision.

Handwritten signature

Student Embalmer No.

Signed No Embalm

Signed.....

Student Embalmer

Handwritten initials: P1111, 30, P1-11

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.