

FILED JUL 29 1950

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24995

318

1003

State File No. _____

6064

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis - Mo.</u>		c. LENGTH OF STAY (in this place) <u>4 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Mc Credie</u>		d. STREET ADDRESS (If rural, give location) <u>1140</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Children's Hospital</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July - 14 - 1950</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Vicki</u>		b. (Middle) <u>Starr</u>		c. (Last) <u>Lay</u>		5. SEX <u>Female</u>	
6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>		8. DATE OF BIRTH <u>Feb - 1 - 1947</u>		9. AGE (In years last birthday) <u>3 yr</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Wichita - Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Norman Lay</u>		13b. MOTHER'S MAIDEN NAME <u>Clover Smith</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Norman Lay, McCredie, Mo.</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>Brain Abscess</u> 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 <u>11 days</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) _____			
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? <u>342X</u>			
22. I hereby certify that I attended the deceased from <u>7-10 1950</u> , to <u>7-14 1950</u> , that I last saw the deceased alive on <u>7-14 1950</u> , and that death occurred at <u>4:10 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Wm. H. Klingberg M.D.</u>				23b. ADDRESS _____		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>7-14-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Fulton, Mo.</u>		24d. LOCATION (City, town, or county) (State) _____	
DATE REC'D BY LOCAL <u>JUL 14 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Farster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

1861

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.

Student Embalmer No.

Signed _____

Licensed Embalmer No. 3653

Signed.....
Student Embalmer

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.