FILED OCT 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32133

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2189

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Normandy
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Normandy Osteopathic Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Normandy 4171
d. STREET ADDRESS (If rural, give location) 7701 Florissant Rd. 0

3. NAME OF DECEASED (Type or Print) a. (First) Baby b. (Middle) c. (Last) Hesse

4. DATE OF DEATH (Month) (Day) (Year) Sept. 16, 1950

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH 9/16/50
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 1 Min. 6

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 Co., Missouri
12. CITIZEN OF WHAT COUNTRY? ---

13a. FATHER'S NAME Rex B. Hesse
13b. MOTHER'S MAIDEN NAME Jean B. (Unknown)
14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Rex Hesse, 7701 Florissant Rd. ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pre mature Birth

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Respiratory Failure

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: 7735

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/16, 1950, *to* 9/17, 1950, *that I last saw the deceased alive on* 9/17, 1950, *and that death occurred at* 12 15A *m., from the causes and on the date stated above.*

23a. SIGNATURE Dr Cn Salerno (Degree or title) D.O.
23b. ADDRESS 7320 Florissant Rd
23c. DATE SIGNED 9/19/50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/16/50
24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.
24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri

DATE REC'D BY LOCAL REG. 9-16-50
REGISTRAR'S SIGNATURE Herbert R. Domke MD
25. FUNERAL DIRECTOR'S SIGNATURE PROVOST UND. CO., 3710 N. Grand Bl. ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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

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 Albert Mayfield

Signed.....
Student Embalmer

Licensed Embalmer No. 3077

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.