

FILED OCT 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35280**

BIRTH NO. **70139-00** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1005** Registrar's No. **8905**

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 MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) 5	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS MATERNITY HOSPITAL		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2059	
f. STREET ADDRESS 5403 MAPLE AVE.		g. (If rural, give location)	
3. NAME OF DECEASED a. (First) Infant (Type or Print)		b. (Middle)	
c. (Last) ROYCE		4. DATE OF DEATH (Month) (Day) (Year) OCTOBER 18 50	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH OCTOBER 18 50
9. AGE (In years last birthday) 3 (Months) 10 (Days) 40		10. USUAL OCCUPATION (If the kind of work done during most of working life, even if retired) infant	
11. BIRTHPLACE (State or foreign country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME ROBERT KILLIAN ROYCE		13b. MOTHER'S MAIDEN NAME VIRGINIA GANT SPITES	
14. NAME OF HUSBAND OR WIFE nil ----		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no ----	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Robert K. Royce, Beaumont Med. Bldg.	
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) Cerebral Hemorrhage ANTECEDENT CAUSES DUE TO (b) Shock DUE TO (c) Premature Separation of Placenta II. OTHER SIGNIFICANT CONDITIONS Premature Separation of Placenta Conditions contributing to the death but not related to the disease or condition causing death.	
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? 760.5	
22. I hereby certify that I attended the deceased from Oct. 18, 1950 , to Oct. 18, 1950 , that I last saw the deceased alive on Oct. 18, 1950 , and that death occurred at 11:55 PM , from the causes and on the date stated above.			
23a. SIGNATURE John Stobbs, M.D.		23b. ADDRESS 630 S. Kings Highway	
23c. DATE SIGNED 10/19/50			
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 10-20-1950	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
DATE REC'D BY LOCAL REG. OCT 20 1950	REGISTRAR'S SIGNATURE J B Bassler	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

Elton R. Renshaw

Licensed Embalmer No. 4283

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.