

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35340

FILED OCT 27 1950

State File No. _____
Registrar's No. 8918

BIRTH NO. 1-16-38-49 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	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.,</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u> <u>2237</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1</u>		d. STREET ADDRESS (If rural, give location) <u>St. Louis City Hosp. #1</u>	

3. NAME OF DECEASED (Type or Print) <u>Baby Boy</u>			a. (First)		b. (Middle)		c. (Last) <u>Smith</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 9, 1950</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>			8. DATE OF BIRTH <u>9-9-49</u>		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months <u>1</u>	IF UNDER 11 HRS. Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME <u>Mary Ellen Weeks</u>			14. NAME OF HUSBAND OR WIFE		
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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 <u>City Hospital Records</u>				ADDRESS <u>1515 Lafayette</u>	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congenital Heart Disease with Myocardial Failure.</u>						INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
		DUE TO (b) <u>Patent Ductus Arteriosus</u>							
		DUE TO (c) <u>Patent Foramen Ovale</u>							
		<u>Interventricular Septal Defect</u>							
		<u>Rt. Ventricular Hypertrophy</u>							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Mongolism</u>							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>13 ft. H.</u>	

22. I hereby certify that I attended the deceased from 9/9, 1949 to 10/9, 1950 that I last saw the deceased alive on 10/9, 1950, and that death occurred at 6:15 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>FREEDMAN</u> <u>Robert H. Freedman, M.D.</u>		(Degree or title) <u>D</u>		23b. ADDRESS <u>1515 Lafayette v.</u>		23c. DATE SIGNED <u>10/10/50</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		24b. DATE <u>10-21-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>City Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>OCT 21 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Pasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>City Hospital</u>		ADDRESS <u>1515 Lafayette Av.</u>	
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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.....

Signed.....
Student Embalmer

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.