

FILED NOV 3 1950

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

State File No. 35411
8984

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

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St. Louis</i>		a. STATE <i>Illinois</i> b. COUNTY	
c. LENGTH OF STAY (In this place) <i>1 mo. 27 days</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Flora</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Louis Children's Hospital</i>		d. STREET ADDRESS (If rural, give location) <i>249 Valbert St.</i>	
3. NAME OF DECEASED a. (First) <i>Jama</i> b. (Middle) <i>Dale</i> c. (Last) <i>Valbert</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>October 21-1950</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>never married</i>	8. DATE OF BIRTH <i>Aug-25-1950</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>infant</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>----</i>	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <i>1 mo. 27 days</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>infant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>----</i>	11. BIRTHPLACE (State or foreign country) <i>Salem - Ill.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13a. FATHER'S NAME <i>Lealie Valbert</i>	
13b. MOTHER'S MAIDEN NAME <i>Mayorie M. Duffel</i>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT'S SIGNATURE OR NAME <i>Childrens Hospital Records</i>		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>St. Louis infection</i>			
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Parasurini deficiency</i> DUE TO (c) <i>Potassium</i>			
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	
20. AUTOPSY? YES <input 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? <i>773.0</i>			
22. I hereby certify that I attended the deceased from <i>8-28-1950</i> , to <i>10-21-1950</i> , that I last saw the deceased alive on <i>10-21-1950</i> , and that death occurred at <i>6:24 p.m.</i> , from the causes and on the date stated above.			
23a. SIGNATURE <i>Dr. L. Johnson M.D.</i>		23b. ADDRESS <i>St. Louis Childrens Hospital</i>	
23c. DATE SIGNED <i>10-21-50</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>		24b. DATE <i>10-22-50</i>	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <i>Flora, Illinois</i>	
DATE REC'D BY LOCAL REG. <i>OCT 23 1950</i>		REGISTRAR'S SIGNATURE <i>J. B. Sarator</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Albert H. Hoppe</i>		ADDRESS <i>4700 Washington</i>	

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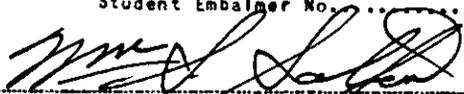
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

working under my personal supervision.

Student Embalmer No.

Signed



Signed.....

Student Embalmer

Licensed Embalmer No. 4699

P. O. Address A. Charles, 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.