

STANDARD CERTIFICATE OF DEATH

#117053

BIRTH NO. 76-9-20-50 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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write BURAL and give township) St. Louis, Mo.		c. CITY (If outside corporate limits, write BURAL and give township) St. Louis 2229	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 27 1206 Morrison Ave., 6	

3. NAME OF DECEASED (Type or Print) Baby Infant		a. (First) b. (Middle) c. (Last) CHARLES		4. DATE OF DEATH (Month) (Day) (Year) Nov. 27th, 1950	
5. SEX male 0	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) newborn 0	8. DATE OF BIRTH 11/27/50	9. AGE (In years last birthday)	9. AGE (In years last birthday) Months Days 1 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis City Hospital #1.	

13a. FATHER'S NAME James Charles		13b. MOTHER'S MAIDEN NAME Betty Moore		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)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS M. Renard St. Louis City Hospital #1.	

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) None viable premature ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
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? 776X	

22. I hereby certify that I attended the deceased from 11/27/50, 18:50 to 11/27/50, 19:00; that I last saw the deceased alive on 11/27/50, 19:00, and that death occurred at 8:50 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert Z. Korn M.D.		23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 11/27/50	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. JAN 9 1951		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State)					

DATE REC'D BY LOCAL REG JAN 9 1951		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service Inc.	
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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.