

FILED FEB 23 1951

STANDARD CERTIFICATE OF DEATH

State File No. 1303

318

1003

BIRTH NO. 30297-50 REG. DIST. NO. PRIMARY REG. DIST. NO. Registrar's No.

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 St. Louis, Mo.,		b. COUNTY Missouri	
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 5533 Cates Ave.,	

3. NAME OF DECEASED (Type or Print)	a. (First) Stephen	b. (Middle)	c. (Last) Lake	4. DATE OF DEATH (Month) (Day) (Year) Jan. 18, 1951
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5. SEX 0 male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH May 29th, 1950	9. AGE (In years last birthday) 8 months	10. MONTHS	11. HOURS	12. MIN.
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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) 9 unknown	12. CITIZEN OF WHAT COUNTRY? 1
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13a. FATHER'S NAME Chester Lake	13b. MOTHER'S MAIDEN NAME Euline Greg	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME M.A. Renard, St. Louis	ADDRESS City Hospital #1.
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Acute bronchiolitis		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diarrhea etiology unknown Mongolism			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input 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)
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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? HAIL
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22. I hereby certify that I attended the deceased from 6/7 1950, to 1/18 1951, that I last saw the deceased alive on 1/18 1951, and that death occurred at 3:10 P.M., from the causes and on the date stated above.

23a. SIGNATURE J.W. Burrows MD	23b. ADDRESS 1515 La Fayette Av.	23c. DATE SIGNED 1/18/51
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. FEB 9 1951	24c. NAME OF CEMETERY OR CREMATORY St. Louis City Cemetery	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. OFF. FEB 9 1951	REGISTRAR'S SIGNATURE J.B. Casper	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

.....  
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.