S. No. 300
V. 10.48

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

FILED APR 9 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10063

BIRTH NO. 24433-51 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2895

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. ANTHONY HOSP

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS. 24 2349
d. STREET ADDRESS (If rural, give location): 3003 A. LEMP

3. NAME OF DECEASED (Type or Print)
a. (First): Infant
b. (Middle):
c. (Last): EWERSMAN.

4. DATE OF DEATH (Month) (Day) (Year): MAR 27 1951

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0

8. DATE OF BIRTH: MAR 27 1951

9. AGE (In years last birthday): If under 1 year: Months: Days: If under 24 hrs.: Hours: 4 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): MISSOURI 0

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: ROBERT. J. EWERSMAN

13b. MOTHER'S MAIDEN NAME: JUSTINE J. SCHAFER

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: ROBERT. EWERSMAN **ADDRESS**: 3003 A LEMP.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Premature — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Maternal cause —
DUE TO (c): Polyhydramnios — 2 weeks

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 ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: 775X

22. *I hereby certify that I attended the deceased from* 3-27, 1951, *to* 3-27, 1951, *that I last saw the deceased alive on* 3-27, 1951, *and that death occurred at* 10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Joseph A. Mueller (Degree or title): M.D.
23b. ADDRESS: 4924 So. Grand
23c. DATE SIGNED: 3-28-51

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: MAR 28 1951
24c. NAME OF CEMETERY OR CREMATORY: RESURRECTION CEM.
24d. LOCATION (City, town, or county) (State): ST. LOUIS. MO.

DATE REC'D BY LOCAL REG.: MAR 28 1951
REGISTRAR'S SIGNATURE: J. B. Lassiter
25. FUNERAL DIRECTOR'S SIGNATURE: Thomas Kutis **ADDRESS**: 2906 Gravois Ave.

(Licensed Embalmer's Statement on Reverse Side)

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. Not Embalmed

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.