

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13951

State File No.

FILED MAY 4 1951		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3845	
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 RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2019			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital				f. STREET ADDRESS (If rural, give location) 6309 Minnesota			
3. NAME OF DECEASED (Type or Print) Infant Daniels			a. (First) b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Apr. 23, 1951	
5. SEX Male <input type="radio"/>		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH Apr. 23, 1951	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) St. Louis, Mo. <input type="radio"/>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Wm. Daniels			13b. MOTHER'S MAIDEN NAME Hazel Steinhans			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="radio"/> no		16. SOCIAL SECURITY NO. <input type="radio"/> no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wm. Daniels 6309 Minnesota			
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 birth (7 mo) ANTECEDENT CAUSES Morbid 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.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		21f. HOW DID INJURY OCCUR? 776X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from Apr 23, 1951, to Apr 24, 1951, that I last saw the deceased alive on Apr 24, 1951, and that death occurred at 1:04 p.m., from the causes and on the date stated above.							
23a. SIGNATURE Roy C. [Signature] (Degree or title)				23b. ADDRESS 7706 [Address]		23c. DATE SIGNED 4/24/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-24-51		24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cem.		24d. LOCATION (City, town, or county) (State) Lemay, Mo.	
DATE REC'D BY LOCAL REG. APR 24 1951		REGISTRAR'S SIGNATURE J. B. [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home		ADDRESS 6322 S. Grand Blvd.	

(Licensed Embalmer's Statement on Reverse Side)

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. *not Embalmed* Student Embalmer No. _____

Student
Student Embalmer

Signed *David Van Trosen*

Licensed Embalmer No. *4243*

P. O. Address. *6322 So. Hill*

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.