

FILED SEP 13 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28214
7864
Registrar's No. 0

BIRTH NO. 56125-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1008

1. PLACE OF DEATH a. COUNTY 0		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 town) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo. 2159	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hosp #1		15 STREET ADDRESS (If rural, give location) 4340 South Main 0	
3. NAME OF DECEASED (Type or Print) a. (First) Baby Boy Erxle b. (Middle) Erxleben c. (Last) Erxleben		4. DATE OF DEATH (Month) (Day) (Year) August 5, 1951	
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH 8-5-51
9. AGE (In years last birthday) 2		10. UNDER 1 YEAR Months 0	10. UNDER 24 HRS. Hours 2 Min. 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Earl Erxleben	
13b. MOTHER'S MAIDEN NAME Mary Cahquette		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 Hospital Record		ADDRESS	

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) Prematurity 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 5 hrs.
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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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 8-5-51, to 8-5-51, that I last saw the deceased alive on 8-5-51, and that death occurred at 7:20A.M., from the causes and on the date stated above.

23a. SIGNATURE (Doctor or title) Clayton R. Brooks, M.D.	23b. ADDRESS 1515 Lafayette	23c. DATE SIGNED 8-6-51
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE SEP 5 1951	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board
24d. LOCATION (City, town, or county) (State)	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Romaine Mortuary Service 4104 Manchester Ave.	
DATE REC'D BY LOCAL REG. SEP 5 1951	REGISTRAR'S SIGNATURE Earl Smith, M.D. No 93	

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.