

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28910

State File No.

FILED SEP 7 1951

BIRTH NO. 58270-51 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 3010

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>CLAYTON</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>9 TOWN KINLOCH MO 4091</u>	
c. LENGTH OF STAY (In this place) <u>30 MIN.</u>		d. STREET ADDRESS (If rural, give location) <u>SCOTT + MCGOWEN</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>ST. LOUIS COUNTY HOSP</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Baby</u> b. (Middle) <u>GIRL</u> c. (Last) <u>DAVIS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8-11-51</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>8-11-51</u>
9. AGE (In years last birthday) <u>3</u>		10. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (State or foreign country) <u>CLAYTON MO. O</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME <u>HOSEA DAVIS</u>	13b. MOTHER'S MAIDEN NAME <u>BLUEMELLE JONES</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
---------------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. B. DAVIS</u> ADDRESS <u>SCOTT + MCGOWEN</u>
--	-------------------------------------	---

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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>neo-natal asphyxiation</u>		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) <u>cord compression</u>		
	DUE TO (c) <u>breach presentation & cord wrapped around buttocks</u>		
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 <u>7615</u>	20. AUTOPSY? YES <input checked="" 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

I hereby certify that I attended the deceased from 8-11-1951, to 8-11-1951, that I last saw the deceased alive on 8-11-1951, and that death occurred at 12:45pm., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) <u>William L. Naughtmann M.D.</u>	22b. ADDRESS <u>601 S. Brentwood Clayton</u>	22c. DATE SIGNED <u>8-29-51</u>
--	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY <u>St. Louis CREMATORY</u>	24d. LOCATION (City, town, or county) (State) <u>5800 ARSENAL St. Louis Mo.</u>
--	-----------	---	---

DATE REC'D BY LOCAL REG. <u>8-29-51</u>	REGISTRAR'S SIGNATURE <u>Robert P. Tomke M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>St. Louis County Hospital</u> ADDRESS <u>1615 S. Park Clayton, Mo.</u>
---	---	--

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

330.

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

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.