

FILED NOV 24 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38931**
Registrar's No. **9848**

BIRTH NO. 17662-51 REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If rural, give location) 5969-Horton Place	

3. NAME OF DECEASED (Type or Print) Debra Kathie Drewes			4. DATE OF DEATH (Month) (Day) (Year) Nov. 5, 1951		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never, married	8. DATE OF BIRTH July 8, 1951	9. AGE (In years last birthday) 3 28	
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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 XXXXXXXXXXXX	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Theodore Drewes Jr.	13b. MOTHER'S MAIDEN NAME Dorothy J. Wehmeyer	14. NAME OF HUSBAND OR WIFE XXXXXXXXXX
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Theodore Drewes	ADDRESS 5669-Horton Pl-St. Louis, Mo
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 110-cecal - Intussusception		INTERVAL BETWEEN ONSET AND DEATH 48 hrs
	ANTECEDENT CAUSES Peritonitis		
	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.			

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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 370.0
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22. I hereby certify that I attended the deceased from Nov 2, 1951, to Nov 5, 1951, that I last saw the deceased alive on Nov 4, 1951, and that death occurred at 3 a. m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i> (Degree or title)	23b. ADDRESS 3720 Washington	23c. DATE SIGNED 11/7/51
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24a. BURIAL CREMATION, REMOVAL (Specify) 4	24b. DATE 11-7-1951	24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens	24d. LOCATION (City, town, or county) (State) Wellston, Mo.
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DATE REC'D BY LOCAL REG. NOV 7 1951	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE Baumann Bros Inc.	ADDRESS 2504-Woodson Rd-Overland-11-Mo.
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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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Oscar F Muller

Licensed Embalmer No. 3039

P. O. Address Overland 14 Mo.

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.