

BIRTH NO. 41490-57 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>MO</i> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <i>St. Louis MO.</i>		c. CITY (If outside corporate limits, write RURAL and give township) <i>Sikeston, MO 1003</i>	
c. LENGTH OF STAY (in this place) <i>4</i>		d. STREET ADDRESS (If rural, give location) <i>St. Louis Childrens Hosp.</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <i>Elizabeth</i> b. (Middle) <i>Sue</i> c. (Last) <i>Rae</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>11 20 - 51</i>		
5. SEX <i>female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>0</i>	
8. DATE OF BIRTH <i>5-30-51</i>		9. AGE (in years last birthday) <i>5 20</i>		10. KIND OF BUSINESS OR INDUSTRY <i>0</i>	
11. BIRTHPLACE (State or foreign country) <i>0</i>			12. CITIZEN OF WHAT COUNTRY?		

13a. FATHER'S NAME <i>Lee Rae</i>		13b. MOTHER'S MAIDEN NAME <i>Cora Gilbert</i>		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 ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Pulmonary Atelectasis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		DUE TO (b) <i>Anesthesia & Operation</i>			
		DUE TO (c) <i>Underlying pulmonary atelectasis</i>		<i>5 mo.</i>	
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					

19a. DATE OF OPERATION <i>11-20-51</i>		19b. MAJOR FINDINGS OF OPERATION <i>Emphysematous RHL & RML of lung.</i>		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>7 1/2 a.m.</i>	

22. I hereby certify that I attended the deceased from *10-23-51*, 19*51*, to *11-20*, 19*51*, that I last saw the deceased alive on *11-20*, 19*51*, and that death occurred at *4 P* m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Dr. L. Smith M.D.</i>		23b. ADDRESS		23c. DATE SIGNED	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removed</i>		24b. DATE <i>9-21-51</i>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <i>Sikeston MO.</i>	
DATE REC'D BY LOCAL REG. <i>NOV 21 1951</i>		REGISTRAR'S SIGNATURE <i>J. Earl Smith M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>McLaughlin</i>		ADDRESS <i>2301 Lafayette</i>	

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

H. G. Harris

Signed.....
Student Embalmer

Licensed Embalmer No. *3384*

P. O. Address *2301 Lafayette*

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.