S. No. 300
. 10.48

FILED DEC 20 1951

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42862

BIRTH NO. 79616-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8903

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis.

c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Johns Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY St. Louis

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Clayton 4442

d. STREET ADDRESS (If rural, give location) R.R. 1 Box 313 Clayton

3. NAME OF DECEASED (Type or Print) a. (First) Infant b. (Middle) c. (Last) Danns

4. DATE OF DEATH (Month) (Day) (Year) Oct. 6, 1951

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) —

8. DATE OF BIRTH Oct 5, 1951

9. AGE (In years last birthday) If under 1 year: Months Days; If under 24 hrs.: Hours Min. 19

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) St. Louis Mo.

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME John J. Danns

13b. MOTHER'S MAIDEN NAME Maryann Monahan

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 John J. Danns R.R. 1 313 Clayton 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) Erythroblastosis fetalis — INTERVAL BETWEEN ONSET AND DEATH 16 1/2 hours

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. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION No operations

20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? 770.0

22. *I hereby certify that I attended the deceased from* Oct 5, 1951, *to* Oct 6, 1951, *that I last saw the deceased alive on* Oct 6, 1951, *and that death occurred at* 2:35 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Raymond J. LaDrare, M.D.

23b. ADDRESS 35 N. Central Ave - Clayton 5

23c. DATE SIGNED 10-8-51

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 9-1951

24c. NAME OF CEMETERY OR CREMATORY Calvary Cem

24d. LOCATION (City, town, or county) (State) St. Louis Mo.

DATE REC'D BY LOCAL REG. Oct 9 1951

REGISTRAR'S SIGNATURE J. Earl Smith M.D. W.B.

25. FUNERAL DIRECTOR'S SIGNATURE M. J. Coghan 7146 ADDRESS Manchester

(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 Not Embalmed,

working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No. 4366

P. O. Address St. Louis 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.