

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH **1003**

42869

State File No. _____

FILED JAN 10 1952

318

Registrar's No. **11346**

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 2119	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) 1922A No. Grand Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1			

3. NAME OF DECEASED (Type or Print) a. (First) DONALD b. (Middle) Ray c. (Last) DAY			4. DATE OF DEATH (Month) (Day) (Year) DEC. 19, 1951		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1950		9. AGE (In years last birthday) 1 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME Cecil Day		13b. MOTHER'S MAIDEN NAME Elsie Hall Day		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Cecil Day, 1922A No. Grand Ave. St. Louis	

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, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Septicemia		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 (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"/>	
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? 0571	

22. I hereby certify that I attended the deceased from **12-19-51**, 19___, to **12-19-51**, 19___, that I last saw the deceased alive on **12-19-51**, 19___, and that death occurred at **9:30Pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert L. Kohn M.D.		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 12-20-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-22-51		24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	
		24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.			

DATE REC'D BY LOCAL REG. DEC 21 1951		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin Funeral Home, Inc	
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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

H. J. Farris

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.