

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18844**

No. 300
18-48

FILED JUN 2 1952

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **547** Registrar's No. **1392**

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

1. PLACE OF DEATH ST. MARYS HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)	
a. COUNTY ST. LOUIS		a. STATE MISSOURI	b. COUNTY ST. LOUIS
b. CITY (If outside corporate limits, write RURAL and give township) RICHMOND HEIGHTS	c. LENGTH OF STAY (In this place) 4 WEEKS	c. CITY (If outside corporate limits, write RURAL and give township) UNIVERSITY CITY 4366	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. MARYS HOSPITAL		d. STREET ADDRESS (If rural, give location) 8231 MONTREAL DR.	
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)
a. (First) CAROL	b. (Middle) ANN	c. (Last) Mc ENTEE	MAY 27 1952
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE A	8. DATE OF BIRTH DEC. 16 1949
9. AGE (In years last birthday) 2		10. MONTHS 5	11. DAYS 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS Mo. U
12. CITIZEN OF WHAT COUNTRY? V.S.A.		13. FATHER'S NAME THOMAS J. McENTEE	
13b. MOTHER'S MAIDEN NAME CLARA M. STUCKENBERG		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME THOMAS J. McENTEE		ADDRESS 8231 MONTREAL DR.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital cyanotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 5 mo.	
ANTECEDENT CAUSES		DUE TO (b) (Transposition of great vessels?)	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS		Anemia 7546	
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 5-27-52	19b. MAJOR FINDINGS OF OPERATION Stenosis of pulmonary artery.		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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR	
22. I hereby certify that I attended the deceased from 4-29 , 19 52 , to 5-27 , 19 52 , that I last saw the deceased alive on May 27 , 19 52 , and that death occurred at 6:15 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE C. Rollin Haslam M.D. (Degree or title)		23b. ADDRESS 1325 S. GRAND BLVD	23c. DATE SIGNED 5-28-52
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAY 29-52	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
DATE REC'D BY LOCAL REG. 5-28-52	REGISTRAR'S SIGNATURE Herbert R. Donke M.D.	25. FUNERAL DIRECTOR'S SIGNATURE H. Boeklage ADDRESS 6536 Clayton St.	

*Sw. Licensed Embalmer's Statement on Reverse Side

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

John J. Harris

Licensed Embalmer No. *4108*

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.