

No. 30
10-48

FILED JUN 6 1952

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18963

BIRTH NO. 47678 REG. DIST. NO. 217 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1370

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) NORMANDY		c. CITY (If outside corporate limits, write RURAL and give township): 20 TOWN ST. LOUIS, 2209	
d. FULL NAME OF HOSPITAL OR INSTITUTION NORMANDY OSTEOPATHIC HOSPITAL		d. STREET ADDRESS (If rural, give location) 3602 b. NO. 22ND ST.	

3. NAME OF DECEASED (Type or Print) a. (First) INFANT c. (Last) PINKSTON			4. DATE OF DEATH (Month) (Day) (Year) 5/22/52		
---	--	--	--	--	--

5. SEX 8	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE 0	8. DATE OF BIRTH 5/22/52	9. AGE (In years last birthday) 5	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
-------------	---------------------------	--	-----------------------------	---	---------------------------	---------------------------	-------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ST. LOUIS COUNTY MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	---	--

13a. FATHER'S NAME MAX PINKSTON	13b. MOTHER'S MAIDEN NAME CHARLETTA AMES	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) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME MAX PINKSTON	ADDRESS 3602 b. NO 20TH ST.
--	---------------------------------	---	--------------------------------

18. CAUSE OF DEATH Enter only the cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Respiratory failure</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Medullary Edema & Cerebral effusion</i> DUE TO (c) <i>Renal failure</i>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Congenital Anomalous Kidney</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <i>7730</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)	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 *5-22-52*, 1952, to *5-22-52*, 1952, that I last saw the deceased alive on *5-22-52*, 1952, and that death occurred at *10:15 p.m.*, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Robert W. Shelby M.D.</i>	23b. ADDRESS <i>6401 W. Florissant</i>	23c. DATE SIGNED <i>5-23-52</i>
--	---	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE <i>5/23/52</i>	24c. NAME OF CEMETERY OR CREMATORY MT LEBANON CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO.
---	-----------------------------	---	---

DATE REC'D BY LOCAL REG. <i>5-23-52</i>	REGISTRAR'S SIGNATURE <i>Herbert L. Poulke M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>STROOT - CARROLL</i>	ADDRESS 4600 NATURAL BRIDGE
--	--	---	--------------------------------

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

Albert Mayfield

Signed.....
Student Embalmer

Licensed Embalmer No.

3077

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.