

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43917**

BIRTH NO. **22828** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11197**

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|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE | | b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give town) | | c. LENGTH OF STAY (in this place) | | c. CITY (If outside corporate limits, write RURAL and give township) | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | d. STREET ADDRESS | | | |

1. PLACE OF DEATH: a. COUNTY: **St. Louis**
b. CITY: **St. Louis**
c. LENGTH OF STAY: **Mo**
d. FULL NAME OF HOSPITAL OR INSTITUTION: **St. John's Hosp.**
2. USUAL RESIDENCE: a. STATE: **Mo**
b. COUNTY: **St. Louis**
c. CITY: **St. Louis County**
d. STREET ADDRESS: **4331 Doswell 14390**

| | | | |
|---|--|-----------------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| 5. SEX | | 6. COLOR OR RACE | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | | 8. DATE OF BIRTH | |
| 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) | | 12. CITIZEN OF WHAT COUNTRY? | |

3. NAME OF DECEASED: **INFANT**
4. DATE OF DEATH: **Dec. 4. 1952**
5. SEX: **M.**
6. COLOR OR RACE: **W**
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED: **0**
8. DATE OF BIRTH: **Dec 2 1952**
10a. USUAL OCCUPATION: **None**
10b. KIND OF BUSINESS OR INDUSTRY: **None**
11. BIRTHPLACE: **St. Louis Mo**
12. CITIZEN OF WHAT COUNTRY: **Mo**

| | | | | | |
|---|--|---------------------------|--|-----------------------------------|--|
| 13a. FATHER'S NAME | | 13b. MOTHER'S MAIDEN NAME | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME | |

13a. FATHER'S NAME: **John Whalen**
13b. MOTHER'S MAIDEN NAME: **Eileen Shea**
14. NAME OF HUSBAND OR WIFE: **John Whalen**
15. WAS DECEASED EVER IN U.S. ARMED FORCES?: **No**
16. SOCIAL SECURITY NO.: **None**
17. INFORMANT'S SIGNATURE OR NAME: **John Whalen**
ADDRESS: **4331 Doswell**

| | | | | | |
|------------------------|--|----------------------------------|--|----------------------------------|--|
| 18. CAUSE OF DEATH | | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | |

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Anencephalus**
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) **Broncho-Pneumonia**
DUE TO (c) **Broncho-Pneumonia**
II. OTHER SIGNIFICANT CONDITIONS*
Conditions contributing to the death but not related to the disease or condition causing death.
19a. DATE OF OPERATION: **None**
19b. MAJOR FINDINGS OF OPERATION: **None**
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) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

21a. ACCIDENT SUICIDE HOMICIDE: **None**
21b. PLACE OF INJURY: **None**
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): **St. Louis Mo**
21d. TIME OF INJURY: **None**
21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR?: **None**

22. I hereby certify that I attended the deceased from **Dec 2 1952** to **Dec 5 1952**, that I last saw the deceased alive on **Dec 5 1952** and that death occurred at **9:30 m.**, from the causes and on the date stated above.

| | | | | | |
|---|--|--------------|--|------------------------------------|--|
| 23a. SIGNATURE (Degree or title) | | 23b. ADDRESS | | 23c. DATE SIGNED | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE | | 24c. NAME OF CEMETERY OR CREMATORY | |
| 24d. LOCATION (City, town, or county) | | 24e. (State) | | | |

23a. SIGNATURE: **Dr. Matthew Weiss, M.D.**
23b. ADDRESS: **634 N. Grand**
23c. DATE SIGNED: **12/5/52**
24a. BURIAL, CREMATION, REMOVAL: **Burial**
24b. DATE: **12-5-52**
24c. NAME OF CEMETERY OR CREMATORY: **Calvary**
24d. LOCATION: **St. Louis Mo**
24e. (State): **Mo**

| | | | | | |
|--------------------------|--|-----------------------|--|----------------------------------|--|
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | |
| 25. ADDRESS | | 26. (State) | | | |

DATE REC'D BY LOCAL REG.: **DEC 5 1952**
REGISTRAR'S SIGNATURE: **J. Earl Smith, M.D.**
25. FUNERAL DIRECTOR'S SIGNATURE: **Vallejos**
25. ADDRESS: **2849 N. Euclid Ave**
26. (State): **Mo**

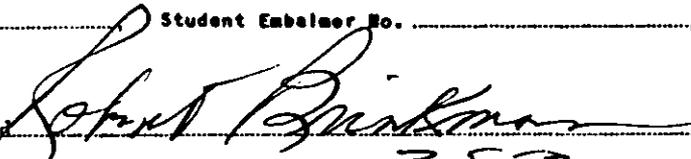
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

..... Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed 

Licensed Embalmer No. 3503

P. O. Address

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.