

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. 4514		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 0731	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place) Life		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2199	
d. FULL NAME OF HOSPITAL OR INSTITUTION Desloge Hospital				d. STREET ADDRESS (If rural, give location) 19 3744 Westminister Place			
3. NAME OF DECEASED (Type or Print) Infant (Female)		a. (First)		b. (Middle)		c. (Last) DeLong	
4. DATE OF DEATH (Month) (Day) (Year) Jan. 21, 1953		5. SEX F.		6. COLOR OR RACE W.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.	
8. DATE OF BIRTH Jan. 21, 1953		9. AGE (In years last birthday)		OF UNDER 1 YEAR Months 0 Days 0		OF UNDER 24 HRS. Hours 0 Min. 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Louie C. DeLong		13b. MOTHER'S MAIDEN NAME Cathleen E. Wheat		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 Mr. Louie C. DeLong, 3744 Westminister Place		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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Atelectasis and ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (a) Bilateral Polycystic Kidneys DUE TO (b) Congenital Malformation II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 7571			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2 p. m. , from the causes and on the date stated above.							
23a. SIGNATURE T. W. Stevenson				23b. ADDRESS No. 634 N Grand		23c. DATE SIGNED 1/22/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan. 22, 1953		24c. NAME OF CEMETERY OR CREMATORY Calvary Cenetry		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. JAN 22 1953		REGISTRAR'S SIGNATURE J. Carl Smith		FUNERAL DIRECTOR'S SIGNATURE Mr. Arthur J. Donnell		ADDRESS 3840 Lindell Blvd.	

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

Wm. J. Sabon

Licensed Embalmer No. *4699*

P. O. Address *St. Charles, 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.