.300
.48

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

FILED JAN 28 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3990

BIRTH NO. 6164 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0181

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St Louis
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Louis Maternity

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: 2179
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
d. STREET ADDRESS (If rural, give location): 17 3238 Copelin

3. NAME OF DECEASED (Type or Print)
a. (First):
b. (Middle):
c. (Last): Zahra

4. DATE OF DEATH (Month) (Day) (Year): January 2 1953

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): --
8. DATE OF BIRTH: January 2 53
9. AGE (In years last birthday): If under 1 year: Months: Days: If under 24 hrs.: Hours: 2 Min.: 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (City and State or Foreign Country): St Louis Missouri
12. CITIZEN OF WHAT COUNTRY?: --

13a. FATHER'S NAME: Raymond Joseph Zahra
13b. MOTHER'S MAIDEN NAME: Ann Elizabeth Hattayer
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): --
16. SOCIAL SECURITY NO.: --
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Raymond & Anne Zahra 3238 Copelin

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~Premature rupture membranes~~ ~~2 hrs~~

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Prematurity Incompatible with life 24 weeks gestation

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death* Premature rupture of membranes 2 hrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 774X

22. *I hereby certify that I attended the deceased from* Jan 2, 19 53, *to* Jan 2, 19 53, *that I last saw the deceased alive on* Jan 2, 19 53, *and that death occurred at* 2:20 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William Berman MD
23b. ADDRESS: 4624 N. Taylor Ave
23c. DATE SIGNED: 1/5/53

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE: 1-31-53
24c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
24d. LOCATION (City, town, or county) (State): St. Louis, Mo.

DATE REC'D BY LOCAL REG. JAN 8 1953
REGISTRAR'S SIGNATURE: J Earl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rowland 4104 Manchester
(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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.