

11436

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No. **2642**No. 300
10-48

FILED MAR 31 1953

BIRTH NO. **17102**REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2079	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 4856 Lee	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) GAYLIA b. (Middle) c. (Last) DAVIS		4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY 7, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Feb. 22, 1952
9. AGE (In years last birthday) 11	10. UNDER 1 YEAR Months 15	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
13a. FATHER'S NAME Charles Davis		13b. MOTHER'S MAIDEN NAME Mae Phillips	
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 Hospital Record		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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningo myelo cele ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hydrocephalus DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input 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? 752x			
22. I hereby certify that I attended the deceased from 2-28-52 , 19__, to 2-7-53 , 19__, that I last saw the deceased alive on 2-7-53 , 19__, and that death occurred at 10:20A m. , from the causes and on the date stated above.			
23. SIGNATURE (Degree or title) George R. Reitzinger M.D.		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 2-10-53			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 3-3-53	
24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. MAR 10 1953		REGISTRAR'S SIGNATURE Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service		ADDRESS 1104 Manchester Ave.	

(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 with the above constitutes grounds for revocation of license.)

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