No. 300
10.48

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

Filed SEP 24 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33005

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8578

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Missouri
c. LENGTH OF STAY (In this place) 10 da.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis Children's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Illinois
b. COUNTY Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Woodriver
d. STREET ADDRESS (If rural, give location) 26 No. Main

8120
8

3. NAME OF DECEASED (Type or Print) a. (First) Frank b. (Middle) N. M. N. c. (Last) Certa
4. DATE OF DEATH (Month) (Day) (Year) 9-1-53
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH 7-11-52.
9. AGE (In years last birthday) 1 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Woodriver, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Anthony J. Certa
13b. MOTHER'S MAIDEN NAME Fannie Spano
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME G. Johnston ADDRESS 500 So. Kingshighway

MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Neuro-muscular dystrophy.
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)
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 ☑ 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) 744.1
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-22, 1953, *to* 8-22, 1953, *that I last saw the deceased alive on* 9-1, 1953, *and that death occurred at* 8:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE G. L. Johnston (Degree or title) M.D.
23b. ADDRESS Children's Hospital
23c. DATE SIGNED 9-3-53

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 5, 1953
24c. NAME OF CEMETERY OR CREMATORY Woodland Hill Ceme.
24d. LOCATION (City, town, or county) (State) Madison County, Illinois.

DATE REC'D BY LOCAL REG. SEP 3 1953
REGISTRAR'S SIGNATURE J. Carl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE Robert H. Streeper. ADDRESS Alton, Ill.
(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 Robert H. Streeper

Licensed Embalmer No. 2474

P. O. Address Alton, Ill.

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.