

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

33917

8000

BIRTH NO. <u>56865</u>		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>8000</u>	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY			
b. CITY OR TOWN <u>St. Louis, Missouri</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>16 3436 Juniata Avenue.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Infant</u>			b. (Middle)		c. (Last) <u>Rall</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 15, 1953</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>August 15, 1953</u>		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant - None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nil</u>	11. BIRTHPLACE (City and State or Foreign Country) <input checked="" type="radio"/>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>William Rall</u>			13b. MOTHER'S MAIDEN NAME <u>Mildred</u>		14. NAME OF HUSBAND OR WIFE <u>Nil</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Nil</u>	17. INFORMANT'S SIGNATURE OR NAME <u>William Rall, 3436 Juniata Ave.</u>		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					INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prec. maturity - Placenta Praevia</u>	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Placenta Praevia</u> DUE TO (c) <u>(C. Section done)</u>						
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or conditions causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>761.5</u>			
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?			
22. I hereby certify that I attended the deceased from <u>Aug 14, 1953</u> , to <u>Aug 15, 1953</u> , that I last saw the deceased alive on <u>Aug 15, 1953</u> , and that death occurred at <u>3:48 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Clifford R. Kasku M.D.</u>				23b. ADDRESS <u>35 no. Central, Clayton</u>		23c. DATE SIGNED <u>8-17-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8-18-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>		
DATE REC'D BY LOCAL REG. <u>AUG 17 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd</u>			

S.P. Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed..... *W. Embalmer*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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