

FILED OCT 30 1953

73288

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 37105

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10034

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Ill.</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>E. St. Louis Ill. 8120</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Marys Infirmary</u>		d. STREET ADDRESS (If rural, give location) <u>1220 Baker Ave. 8</u>	

3. NAME OF DECEASED (Type or Print) <u>Baby</u>			a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 17 1953</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>Negro</u>			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>			8. DATE OF BIRTH <u>Oct. 17, 1953</u>		
9. AGE (In years last birthday) <u>7</u>			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13a. FATHER'S NAME <u>James Cotton</u>			13b. MOTHER'S MAIDEN NAME <u>Earnstine Barber</u>			14. NAME OF HUSBAND OR WIFE <u>-</u>		

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 <u>James Cotton 1303 Rosell Ave.</u>			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congenital Atelectasis</u>		DUPLICATE					
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS <u>Prematurity</u>					
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 <u>7625</u>	

22. I hereby certify that I attended the deceased from Oct 17 1953 to Oct 17, 1953, that I last saw the deceased alive on Oct 17 1953 and that death occurred at 6:20 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Charles A. Antenor</u>		23b. ADDRESS <u>360 Adams E. St. Louis Mo</u>		23c. DATE SIGNED <u>10-17-53</u>	
24a. BURIAL (CREMATION REMOVAL) <u>Removal</u>		24b. DATE <u>10-17-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>E. St. Louis Ill.</u>	
24d. LOCATION (City, town, or county) (State) <u>E. St. Louis Ill.</u>		24e. NAME OF CEMETERY OR CREMATORY <u>E. St. Louis Ill.</u>		24f. LOCATION (City, town, or county) (State) <u>E. St. Louis Ill.</u>	

DATE REC'D BY LOCAL REG. <u>OCT 21 1953</u>		REGISTRAR'S SIGNATURE <u>Charles Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Chippley 1136 Tudor Ave. E. St. Louis Ill.</u>	
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WRITE PLAINLY—USING 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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed.....  
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 the above constitutes grounds for revocation of license.)

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