

FILED APR 29 1954

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 13563

BIRTH NO. 25402-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3449

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 TOWN ST. LOUIS		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN ST. LOUIS		
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hosp		e. STREET ADDRESS (If rural, give location) 20 1725 N. Leffingwell 2209				
3. NAME OF DECEASED (Type or Print) a. (First) Sharon b. (Middle) Lee c. (Last) Hiles		4. DATE OF DEATH (Month) (Day) (Year) 4-16-54				
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 4-14-1954	9. AGE (In years last birthday) 2	IF UNDER 1 YEAR Months	
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 (City and State or Foreign Country) ST. LOUIS MO		
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Lawrence Hiles		13b. MOTHER'S MAIDEN NAME Barbara Dudzik		
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) No		16. SOCIAL SECURITY NO. NONE		
17. INFORMANT'S SIGNATURE OR NAME Lawrence Hiles		18. ADDRESS 1725 Leffingwell				
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CONGENITAL ATELECTASIS 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 45 HOURS	
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) 762.0		
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 15 April, 1954, to 16 April, 1954, that I last saw the deceased alive on 16 April, 1954, and that death occurred at 2:00 PM from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) Gene H. Grobman M.D.		23b. ADDRESS 8201 North Blvd St. Louis		23c. DATE SIGNED 17 April 54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-17-54		24c. NAME OF CEMETERY OR CREMATORY Calvary		
24d. LOCATION (City, town, or county) St. Louis		24e. (State) Mo				
DATE REC'D BY LOCAL REG. APR 17 1954		REGISTRAR'S SIGNATURE J. C. Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. K. & G. Co 2707 91 Grand		

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

STATEMENT BY LICENSED EMBALMER

Not Embalmed

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by, Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
August Keown Jr
Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Falsely 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.