

FILED APR 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14294

State File No.

318

REG. DIST. NO. PRIMARY REG. DIST. NO.

1003

Registrar's No.

3120

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St Louis		c. CITY OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity		e. STREET ADDRESS (If rural, give location) 3212 Pine Street	
3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Wynne		4. DATE OF DEATH (Month) (Day) (Year) March 28 1954	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH March 25 1954
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Mins 3 3 12 45		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (City and State or Foreign Country) St Louis Missouri		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Shelby Wynne		13b. MOTHER'S MAIDEN NAME Lillie Lee Davis	
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)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lillie & Shelby Wynne 3212 Pine St. City	
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) Intracranial hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prematurity DUE TO (c) Preecl. Preeclatation II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Twin Pregnancy	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" 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) 774X	
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?		22. I hereby certify that I attended the deceased from March 25, 1954 to March 28, 1954 , that I last saw the deceased alive on March 28, 1954 , and that death occurred at 4:55 P. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) E.H. Lampe M.D.		23b. ADDRESS Saint Louis Maternity Hosp	
23c. DATE SIGNED 4/2/54		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 4-30-54		24c. NAME OF CEMETERY OR CREMATORY Central Memorial Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland - Sku 4104	
DATE REC'D BY LOCAL REG. APR 7 1954		REGISTRAR'S SIGNATURE Carl Smith M.D.	

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.....

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.**