

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32414**

FILED OCT 14 1954

BIRTH NO. **75025-54** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **541** Registrar's No. **2302**

1. PLACE OF DEATH a. COUNTY <b>St. Louis County</b>		2. USUAL RESIDENCE* (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Clayton</b>		c. CITY OR TOWN <b>Clayton</b> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS COUNTY HOSPITAL</b>		STREET ADDRESS (If rural, give location) <b>601 S. Brentwood</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>BABY</b>	b. (Middle) <b>GIRL</b>	c. (Last) <b>GLEASON</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>SEPT 28 1954</b>
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>SEPT 27, 1954</b>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <b>1</b>	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>County Hosp., Clayton, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Robert Gleason</b>	13b. MOTHER'S MAIDEN NAME <b>Vivian Wallis</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Vivian Gleason,</b>	ADDRESS <b>Lemay, Mo.</b>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Subarachnoid hemorrhage</b>		<b>32 hrs</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Premature onset of labor</b> DUE TO (c) <b>Birth trauma and immaturity (Brah)</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Atelectasis of both lungs</b>			<b>32 hrs</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>7605</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **Sept 27, 1954**, to **Sept 28, 1954**, that I last saw the deceased alive on **Sept 28, 1954**, and that death occurred at **2:50 pm.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Robert P. Pfeiffer MD</b> (Degree or title)	23b. ADDRESS <b>601 S. Brentwood Clayton</b>	23c. DATE SIGNED <b>9/28/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	24b. DATE <b>9/28/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Louis Crematory</b>	24d. LOCATION (City, town, or county) (State) <b>5800 Arsenal, St. Louis, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>10/1/54</b>	REGISTRAR'S SIGNATURE <b>Robert S. Sommers</b>	5. FUNERAL DIRECTOR'S SIGNATURE <b>St. Louis Co. Hosp. Clayton</b>
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(Licensed Emballer's Statement on Reverse Side)

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

No. 300  
10-48

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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.