

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

BIRTH NO. 39358-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1008 Registrar's No. 5199

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 township) St. Louis		c. LENGTH OF STAY (in this place) 5 days 20		c. CITY OR TOWN St. Louis	
d. FULL NAME OF (If not in hospital or institution, give street address or location) St. Louis Childrens Hospital		STREET ADDRESS (If rural, give location) 2519 N 20th St. 2209			
3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH Baby b. (Middle) BOY c. (Last) McHane		4. DATE OF DEATH 6-9-55		5. SEX m	
6. COLOR OR RACE w		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH 5-25-55	
9. AGE (In years last birthday) 15		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis		12. CITIZEN OF WHAT COUNTRY?			

13a. FATHER'S NAME Harold McHane Jr.		13b. MOTHER'S MAIDEN NAME Jacqueline Eggers		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 H. Braun	
				ADDRESS 500 S. Kingshighway	

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sepsis			
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diarrhea DUE TO (c) Prematurity			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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)	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 7645	
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22. I hereby certify that I attended the deceased from 6-4, 1955, to 6-9, 1955, that I last saw the deceased alive on 6-9-1955, and that death occurred at 10:30 AM, from the causes and on the date stated above.

23a. SIGNATURE Dr. P. Huston McO		(Degree or title)		23b. ADDRESS Childrens Hospital	
23c. DATE SIGNED 6-10-55					

24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 6-30-55		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
				24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

DATE REC'D BY LOCAL REG. JUN 16 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland - Dees	
				ADDRESS 4104 Manchester	

(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.....

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.