

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23326

State File No.

FILED JUL 25 1955

BIRTH NO. 24933-55 REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 1831

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

1. PLACE OF DEATH a. COUNTY ST. CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY PIKE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. CHARLES		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Calumet	
c. LENGTH OF STAY (In this place) 3 Mo.		d. STREET ADDRESS (If rural, give location) 0820 7	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH'S Hosp.			
3. NAME OF DECEASED (Type or Print) a. (First) ELIZABETH		b. (Middle) PAULINE	
c. (Last) KITSON		4. DATE OF DEATH (Month) (Day) (Year) JULY 17, 1955	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED NEVER MARRIED	8. DATE OF BIRTH APR. 17, 1955
9. AGE (In years last birthday) 3		10. MONTHS 9 DAYS 27 HOURS MINS. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) MO		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME PAUL KITSON		13b. MOTHER'S MAIDEN NAME SHIRLEY HUNTER	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME SHIRLEY KITSON, ANNADA, Mo.		ADDRESS	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hyaline Membrane ANTECEDENT CAUSES Premature Birth 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. 776x	
INTERVAL BETWEEN ONSET AND DEATH 9 days			
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) (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 APR 17, 1955 , to July 17, 1955 , that I last saw the deceased alive on July 16, 1955 , and that death occurred at 8:35 m., from the causes and on the date stated above.			
23a. SIGNATURE [Signature]		23b. ADDRESS 114 N. Main St. Charles Mo	
23c. DATE SIGNED 7-18-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE July 18, 1955	
24c. NAME OF CEMETERY OR CREMATORY CORINTH		24d. LOCATION (City, town, or county) (State) Foley, Mo	
DATE REC'D BY LOCAL REG. July 22, 1955		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Foley, Mo	

MAR 26 1915

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. _____

Student
Student Embalmer

Signed *[Handwritten Signature]* _____

Licensed Embalmer No. *4012* _____

P. O. Address *Elaberry, Mo* _____

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