

FILED AUG 2-1955

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1003

State File No.

6152

BIRTH NO. 59184-55 REG. DIST. NO. PRIMARY REG. DIST. NO. Registrar's No.

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) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN ST. LOUIS			
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		e. STREET ADDRESS (If rural, give location) 22 2213 HICKORY					
3. NAME OF DECEASED (Type or Print) (First) Rickie (Middle) Darel (Last) BLANKS			4. DATE OF DEATH (Month) (Day) (Year) JULY 13 1955				
5. SEX MALE	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH JULY 11, 1955		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 2		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MISSOURI			
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME FRANK		13b. MOTHER'S MAIDEN NAME DEOLA REEVES			
14. NAME OF HUSBAND OR WIFE NONE		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 HOSPITAL RECORD		17. ADDRESS		17. 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) Pulmonary atelectasis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Multiple congenital anomalies DUE TO (c) Omphalocele II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR? 7620		22. I hereby certify that I attended the deceased from 7-11-55 , 19___, to 7-13-55 , 19___, that I last saw the deceased alive on 7-13-55 , 19___, and that death occurred at 12:05 A.M. , from the causes and on the date stated above.					
23a. SIGNATURE Lon B. Klink (Degree or title) M.D.		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 7-13-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 7-16-55		24c. NAME OF CEMETERY OR CREMATORY GREENWOOD			
24d. LOCATION (City, town, or county) (State) ST LOUIS CO, MO		24e. DATE REC'D BY LOCAL REG. JUL 16 1955		24f. REGISTRAR'S SIGNATURE E. Earl Smith - m			
24g. FUNERAL DIRECTOR'S SIGNATURE Bennie Loue		24h. ADDRESS 3103 Washington		24i. (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. *708*
Howland, C
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.