

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. **23624**

FILED AUG 4 - 1955

BIRTH NO. **59455-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5619**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) OR TOWN Berkley 20	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hosp.		d. STREET ADDRESS (If rural, give location) 4231 Marshall Rd.	
3. NAME OF DECEASED (Type or Print) a. (First) Baby b. (Middle) c. (Last) Cross		4. DATE OF DEATH (Month) (Day) (Year) 6 27 55	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 6/27/55
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) St. Louis Mo.
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Don O'Brien Cross		13b. MOTHER'S MAIDEN NAME Helen Louise Stephens	
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. none		17. INFORMANT'S SIGNATURE OR NAME & HOME ADDRESS Helen Cross 4231 Marshall Rd.	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Immaturity ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Premature birth - 5 mo 3 hr. 30 min. 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.	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 7625		22. I hereby certify that I attended the deceased from 6/27, 1955 , to 6/27, 1955 , that I last saw the deceased alive on 6/27, 1955 , and that death occurred at 12:30 p.m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Kory V. Boedeker M.D.		23b. ADDRESS 453 W. Taylor	
23c. DATE SIGNED 6/27/55		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 6/29/55		24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		DATE REC'D BY LOCAL REG. JUN 29 1955	
REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harral, 1905 Union Blvd.	

— 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
Student Embalmer

Signed

Warren A. Carver

Licensed Embalmer No.

353X

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