

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27638

State File No.

FILED SEP 6 1955

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7264

1. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis
 c. LENGTH OF STAY (in this place) 14 days
 d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
 a. STATE Missouri b. COUNTY _____
 c. CITY OR TOWN St. Louis
 d. Is Residence within limits of a city or incorporated town? Yes No
 e. STREET ADDRESS (If rural, give location) 1011 Emmett 2239

3. NAME OF DECEASED (Type or Print) a. (First) Doyle b. (Middle) Eugene c. (Last) Erwin
 4. DATE OF DEATH (Month) (Day) (Year) 8-17-55

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 8. DATE OF BIRTH 5-22-44 9. AGE (In years last birthday) 11 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (City and State or Foreign Country) Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Robert Homer Erwin 13b. MOTHER'S MAIDEN NAME Lucille Waller 14. NAME OF HUSBAND OR WIFE None

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 E Johnston ADDRESS 500 S. Kingshighway

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Esophageal varices & hemorrhage
 ANTECEDENT CAUSES UNKNOWN DISEASE
 *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.
 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 _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR _____

22. I hereby certify that I attended the deceased from 8-4 1955, to 8-17- 1955, that I last saw the deceased alive on 8-17-55, 1955, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE W. J. Klingberg MD (Degree or title) 23b. ADDRESS St. Louis Children's Hosp. 23c. DATE SIGNED 8-18-1955

24a. BURIAL, CREMATION REMOVAL (Specify) Removal 24b. DATE 8-20-1955 24c. NAME OF CEMETERY OR CREMATORY St. Trinity Lutheran 24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

DATE REC'D BY LOCAL REG. AUG 19 1955 REGISTRAR'S SIGNATURE J. Carl Smith, M.D. 25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin F.H., Inc. ADDRESS 2301 Lafayette

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 *A. G. Farris*.....

Licensed Embalmer No. *338*.....

P. O. Address *St. Louis*.....

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.