

FILED SEP 8 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28038

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7422

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. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 21 2318 Carr Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity		4. DATE OF DEATH (Month) (Day) (Year) August 7 1955	
3. NAME OF DECEASED a. (First) (Type or Print)		b. (Middle) Pendleton	
c. (Last)		5. SEX Female 3	
6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH August 7 1955		9. AGE (In years last birthday) (If under 1 year: Months) (Days) (If under 24 hrs.: Hours) (Mins.) 1 35	
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 Missouri		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Luevella Pendleton	
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 Luevella Pendleton	
		ADDRESS Above	

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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Abnormal pulmonary ventilation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16.35"</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prematurity</u>		
	DUE TO (c)		
11. 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 774X	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)	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 August 7, 1955, to August 7, 1955, that I last saw the deceased alive on August 7, 1955, and that death occurred at 2:40 P.m., from the causes and on the date stated above.

23a. SIGNATURE <u>R. C. Schaan MD</u>	(Degree or title)	23b. ADDRESS <u>630 S. Kings Highway St. Louis, Mo. 63104</u>	23c. DATE SIGNED <u>8/16/55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>8-31-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>

DATE REC'D BY LOCAL REG. <u>AUG 24 1955</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland - No. 4109 Mandeville</u>	ADDRESS
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(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

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