

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18487

State File No. \_\_\_\_\_

5242

BIRTH NO. 34468-56 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) -a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS,</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>Life</b>		e. STREET ADDRESS (If rural, give location) <b>23 713 LAMI</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BETHESDA HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print) <b>KENNETH RADFORD</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>May 30, 1956</b>		
a. (First)	b. (Middle)	c. (Last)	5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>
8. DATE OF BIRTH <b>May 29, 1956</b>			9. AGE (In years last birthday) <b>1</b>	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) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>ST. LOUIS, MISSOURI</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					

13a. FATHER'S NAME <b>CHESTER RADFORD</b>		13b. MOTHER'S MAIDEN NAME <b>DORIS LESTER</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Chester Radford, 731 Lami</b>	
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, athenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION			

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congenital Atelctasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>birth</b>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Prematurity (26 weeks gestation)</b>		
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 <b>762.5</b>		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?	

22. I hereby certify that I attended the deceased from May 29, 1956, to May 30, 1956, that I last saw the deceased alive on May 29, 1956 and that death occurred at 3:30 AM., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Leroy E. Ellison M.D.</b>		23b. ADDRESS <b>3610 So Broadway St. Louis Mo</b>		23c. DATE SIGNED <b>May 31, 1956</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>May 31, 1956</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Lutheran</b>	
				24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>	

DATE REC'D BY LOCAL REG. <b>MAY 31 1956</b>		REGISTRAR'S SIGNATURE <b>Charles Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>McLaughlin F.H., Inc.</b>	
				ADDRESS <b>2301 Lafayette</b>	

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 emb  
by me, or by ..... Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
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.