

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42015-56
FILED JUL 20 1956

25125
STATE FILE NUMBER
1003
6064

Registration District No. 318 Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF DECEASED (If NOT in hospital, give location) ST. LOUIS CITY HOSPITAL #1		Length of stay in lb		d. STREET ADDRESS 3635 COTTAGE	
3. NAME OF DECEASED (Type or print) First BABY BOY Middle MALONEY Last			4. DATE OF DEATH Month MAY Day 31 Year 1956		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 31, 1956	9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months 0 Days 0 Hours 10
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 country) ST. LOUIS, MISSOURI	
13. FATHER'S NAME RAYMOND MALONEY			14. MOTHER'S MAIDEN NAME MARIE WILSON		
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 Address ST. LOUIS CITY HOSPITAL RECORD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 2 hr. 10 min.	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from <u>5/31/56</u> to <u>5/31/56</u> and last saw her alive on <u>5/31/56</u> Death occurred at <u>9:00 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Richard M. Mertes M.D.</i>		22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 6/1/56.	
23a. BURIAL, CREMATION REMOVAL (Specify) JUN 27 1956		23b. DATE 6-30-58		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
23d. LOCATION (City, town, or county) St. Louis, Mo.		23e. STATE (State)		24. FUNERAL DIRECTOR Rowland-Aker Mortuary Service 1114 Manchester Ave. St. Louis 10, Mo.	
25. DATE RECD. BY LOCAL REG. JUN 27 1956		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>			

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.....

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.