

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43487

STATE FILE NUMBER

FILED JAN 15 1957

92102-56

Registration District No.

318

Primary Registration District No.

1003

Registrar's No. 11958

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. CITY OR TOWN <u>ST. LOUIS, MISSOURI</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL #1.</u>		Length of stay in 1b <u>918</u> STREET ADDRESS <u>1411 SO. EWING</u> (If outside, give location) Reside on Farm Yes ☐ No ☐	
3. NAME OF DECEASED (Type or print) First <u>BABY BOY</u> Middle <u>MC</u> Last <u>KINNEY</u>		4. DATE OF DEATH <u>DECEMBER 11, 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH <u>NOV. 8, 1956</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
10a. FATHER'S NAME <u>JAMES</u>		10b. MOTHER'S MAIDEN NAME <u>THELMA SAXTON</u>	
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>NO</u> (If yes, give war or dates of service)		12. SOCIAL SECURITY NO. <u>NO</u>	
13. INFORMANT <u>ST. LOUIS CITY HOSPITAL #1.</u>		Address	
14. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHPNEUMONIA.</u> DUE TO (b) <u>PREMATURITY.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>			
15. INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		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. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>12/8/56</u> to <u>12/11/56</u> and last saw her alive on <u>12/11/56</u> Death occurred at <u>7:25 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W.B. Avery MD.</u> (Degree or title)		22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>	
22c. DATE SIGNED <u>12/ 12/56</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-31-56</u>		23b. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	
23c. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Rowland Akers 410 1/2 Manchester</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>DEC 28 1956</u>	
26. REGISTRAR'S SIGNATURE <u>W.B.</u>			

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. (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.