

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43875
State File No. 12089
Registrar's No.

FILED JAN 15 1957

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH
a. COUNTY
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE ILLINOIS b. COUNTY PIKE

b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS c. LENGTH OF STAY (In this place) (No. Days) 1 mo. 22 days
c. CITY OR TOWN PEARL d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CHILDREN'S HOSPITAL e. STREET ADDRESS (If rural, give location) R.R. #1

3. NAME OF DECEASED a. (First) b. (Middle) c. (Last) 4. DATE OF DEATH (Month) (Day) (Year)
(Type or Print) MARILYN MARIE SIDWELL 12-29-56

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 8. DATE OF BIRTH 9-29-56 9. AGE (In years last birthday) 3 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) ILLINOIS 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME CHARLES L. SIDWELL 13b. MOTHER'S MAIDEN NAME NORMA FULMER 14. NAME OF HUSBAND OR WIFE -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. NONE 17. INFORMANT'S SIGNATURE OR NAME ADDRESS B. Britton 500 S. KINGSHIGHWAY

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) Cardiac and respiratory failure congenital
ANTECEDENT CAUSES DUE TO (b) Complete transposition of the great vessels
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Congenital cyanotic heart disease
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 754.4 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 11-7, 1956 to 12-29, 1956, that I last saw the deceased alive on 12-29, 1956, and that death occurred at 1:58 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Barbara Jones, M.D. 23b. ADDRESS 500 S. KINGSHIGHWAY 23c. DATE SIGNED 12-29-56

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 12-29-56 24c. NAME OF CEMETERY OR CREMATORY 24d. LOCATION (City, town, or county) (State) Pearl, Illinois

DATE REC'D BY LOCAL REG. JAN 2 1957 REGISTRAR'S SIGNATURE Carl Smith M.D. 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hanks, Haddin, Illinois ✓

WRITE PLAINLY—USING UNFAADING 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 *No Embalmed*.....
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.