

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44803

State File No. ....

FILED JAN 29 1957

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11334

BIRTH NO. 46408-56 REG. DIST. NO. .... PRIMARY REG. DIST. NO. .... Registrar's No. ....

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Valley Park 4761</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Evangelical Deaconess Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>904 Marshall Ave.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Curtis</u> b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov-25, 1956</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>Nov-25, 1956</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>1 22</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Rev. James Curtis</u>	13b. MOTHER'S MAIDEN NAME <u>Grace Hill</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. J. Curtis, Valley Park, Mo.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Respiratory difficulty</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>undetermined cause</u> DUE TO (c)		
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	20. AUTOPSY? <u>3</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Nov. 25, 1956, to Nov. 25, 1956, that I last saw the deceased alive on Nov 25, 1956, and that death occurred at 8:20 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Kenneth V. Larsen M.D.</u>	23b. ADDRESS <u>607 N. Grand</u>	23c. DATE SIGNED <u>11-26-56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>12-31-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>DEC 11 1956</u>	REGISTRAR'S SIGNATURE <u>Carl Smith Mo</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rowland-Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo.</u>
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(Licensed Embalmer's Statement on Reverse of St. Louis 10, Mo.)

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.