

Health, Welfare Public Service

300 0-56

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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3056

STATE FILE NUMBER

229

FILED JAN 29 1957  
4479-57

Registration District No. 318

Primary Registration District 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, give TOWNSHIP only) OR TOWN <b>St. Louis MISSOURI</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis, Mo.</b>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hosp. #1</b>				Length of stay in lb <b>1</b>		d. STREET ADDRESS (If outside, give location) <b>1728 Preston</b>	
3. NAME OF DECEASED (Type or print) <b>Baby Girl Saunders</b>				First Middle Last		4. DATE OF DEATH <b>Jan 4 1957</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 4, 1957</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>18</b>	
11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Fred Saunders</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Holpf</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Barbara Saunders</b> Address <b>1728 Preston</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b>						INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <b>776x</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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 Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>1/4/57</b> to <b>1/4/57</b> and last saw her alive on <b>1/4/57</b> . Death occurred at <b>11:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Don B. Klein, M.D.</b>				22b. ADDRESS <b>1515 Lafayette</b>		22c. DATE SIGNED <b>1/8/57</b>	
23a. BURIAL, CREMATION, REMOVAL <b>REMOVAL</b>		23b. DATE <b>1/9/57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Missouri.</b>	
24. FUNERAL DIRECTOR <b>Boyd Bros. Funeral Home</b> ADDRESS <b>18. Kinloch, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 9 '57</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

mdb

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 *Edward A. Flynn*.....

Licensed Embalmer No. *44*

P. O. Address *S. Kenbeck*.....

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.