

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 29 1957

318

1003

State File No. 11095
Registrar's No. 2262

BIRTH NO.		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 a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give town(ship)) St. Louis		c. LENGTH OF STAY (in this place) D.O.A.		c. CITY OR TOWN Edmundson 0		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 38 St. Louis Children's Hospital				e. STREET ADDRESS (If rural, give location) 4611 OTIS			
3. NAME OF DECEASED (Type or Print) a. (First) Benjamin b. (Middle) Hines c. (Last) Skinner			4. DATE OF DEATH 3 7 57				
5. SEX Male 0		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0		8. DATE OF BIRTH 10/12/54	
9. AGE (In years last birthday) 2 4		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) St. Louis 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Harold Skinner		13b. MOTHER'S MAIDEN NAME Ella B. Hines		14. NAME OF HUSBAND OR WIFE Single			
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'S SIGNATURE OR NAME ADDRESS Alice Tombridge, 500 Skings Highway			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intia hepatic & extra hepatic</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>bilary atresia</u> <u>Cardiogenic liver</u> DUE TO (c) <u>Gastrointestinal hemorrhage</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION (a) Above.		756.2		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-26, 1954, to 3-7, 1957, that I last saw the deceased alive on 3-6, 1957, and that death occurred at 12-55 a.m., from the causes and on the date stated above.							
23a. SIGNATURE Robert H. Freedman (Type or title)				23b. ADDRESS Children's Hospital		23c. DATE SIGNED MAR 7 57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-7-57		24c. NAME OF CEMETERY OR CREMATORY Old Clay Cemetery		24d. LOCATION (City, town, or county) (State) Shay, Kentucky	
DATE REC'D BY LOCAL REG. MAR 7 57		REGISTRAR'S SIGNATURE C. L. Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS White Chapel, Ferguson, Mo.			

This child was D.O.A. - Brought in to Hosp. by Dr. Robert Freedman. He has been taking care of child since a wife of age. 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..

No Embalming

Student.....
Signature of Student Embalmer

Signed *R. M. White*

Licensed Embalmer No. *3973*

P. O. Address *Herkman, Me*

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.