

FILED APR 15 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11360**

BIRTH NO. **19200-57** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **531** Registrar's No. **831**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>University City</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>8501 Kempland Avenue</b>	
c. LENGTH OF STAY (In this place) <b>NewBorn</b>		d. STREET ADDRESS (If rural, give location) <b>University City, Mo.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>8501 Kempland</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Baby Girl</b>		b. (Middle)		c. (Last) <b>HOWARD</b>		4. DATE OF DEATH (Month) <b>3</b> (Day) <b>18</b> (Year) <b>57</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED</b>		8. DATE OF BIRTH <b>3/18/57</b>	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME <b>--</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Ellen Howard</b>		14. NAME OF HUSBAND OR WIFE <b>-- NONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO --</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mary Ellen Howard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES?		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES?		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Asphyxia secondary to drowning</b>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>9290</b>					
2. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? / YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>bathroom of home</b>		21c. (CITY, TOWN, OR TOWNSHIP) <b>134</b> (COUNTY) <b>St. Louis</b> (STATE) <b>Mo.</b>	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <b>Mar. 18, 1957 10:30 p.m.</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Mother gave birth to infant while on commode in bathroom of home without medical aid</b>	
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <b>Raymond H. Harris</b> (Degree or title) <b>Coroner</b>		23b. ADDRESS <b>Clayton, Mo.</b>		23c. DATE SIGNED <b>3-26-57</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		24b. DATE <b>3-28-57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Missouri Crematory</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
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DATE REC'D BY LOCAL REG. <b>3/28/57</b>		REGISTRAR'S SIGNATURE <b>Darbert B. Dombke MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>St. Louis County Hospital</b>		ADDRESS	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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.