

Health, Welfare and Public Service  
 300 0  
 1-56  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAY 31 1957

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

18998  
 STATE FILE NUMBER  
 4825

34490-5, 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) <b>ST. LOUIS</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP.</b>			Length of stay in 1b #1.	d. STREET ADDRESS <b>2229 2828 Walnut St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BABY BOY</b>				First Middle Last <b>MC CALISTER</b>		4. DATE OF DEATH Month Day Year <b>MAY 3, 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</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>April 27, 1957</b>		9. AGE (In years last birthday) <b>6</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <b>Gennie McCalister</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</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>Anencephaly</b> DUE TO (b) _____ DUE TO (c) <b>750x</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
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>4/27/57</b> to <b>5/3/57</b> and last saw her <b>him</b> alive on <b>5/3/57</b> Death occurred at <b>9:10 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>William T. Ottomano, M. D.</b>				22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		22c. DATE SIGNED <b>5/3/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>5-31-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>		(State)
24. GENERAL DIRECTOR <b>Rowland Aker 404 Manchester</b>				25. DATE RECD. BY LOCAL REG. <b>MAY 23 '57</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>	

(Licensed Embalmer's Statement on Reverse Side)

