

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED JUN 7 1957

318

1003

State File No. **19111**
Registrar's No. **4960**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. _____ Registrar's No. **4960**

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u> c. LENGTH OF STAY (in this place) <u>8 hrs.</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Children's Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). -a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u> c. CITY OR TOWN <u>Elsberry</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> • STREET ADDRESS (If rural, give location) <u>31 305 N. 2nd</u> <u>0570</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Benjamin</u> b. (Middle) <u>Anthony</u> c. (Last) <u>Naber</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5</u> <u>25</u> <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>0</u>	8. DATE OF BIRTH <u>11-25-55</u>
9. AGE (In years last birthday) <u>1</u>	IF UNDER 1 YEAR Months <u>6</u>	IF UNDER 12 HRS. Days <u>0</u>	IF UNDER 12 MIN. Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>David Aaron Naber</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Collins</u>	
14. NAME OF HUSBAND OR WIFE <u>Single</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Alice Traverhudge, Sec. St. Louis Children's Hospital</u>	
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>meningo-encephalitis</u> ANTECEDENT CAUSES <u>Pneumonia</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>O.K. in 2 weeks</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>good opacity</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Alice Traverhudge, Sec. St. Louis Children's Hospital</u>		ADDRESS	
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>meningo-encephalitis</u> ANTECEDENT CAUSES <u>Pneumonia</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>O.K. in 2 weeks</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>good opacity</u>		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) (m.)		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 5-25, 1957, to 5-25, 1957, that I last saw the deceased alive on 5-25, 1957, and that death occurred at 11:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Barbara Jones, M.D. Children's Hospital</u>		23b. ADDRESS <u>St. Louis, Mo.</u>		23c. DATE SIGNED <u>MAY 27 '57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>5-26-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CITY CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>ELSBERRY, MO.</u>		
DATE REC'D BY LOCAL REG. <u>MAY 27 '57</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>[Signature] MO RICK'S FUNERAL HOME, ELSBERRY, MO</u>		

(Licensed Embalmer's Statement on Reverse Side)

No. 390
 10-4-55
 M. Bernard
 Coronet
 Jaylor - Coronet
 Approved by Miss Jaylor - Coronet
 WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
 1957 is not a common year - Approved by Miss Jaylor - Coronet

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.....
O'Garland Reaks

Licensed Embalmer No. *4012*

P. O. Address *Elaberry,*

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.