

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29541**  
Registrar's No. **7129**

FILED AUG 26 1957

|   |  |   |  |   |   |   |   |  |
|---|--|---|--|---|---|---|---|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>318</b>   |  | PRIMARY REG. DIST. NO. <b>1003</b>  |   | Registrar's No. <b>7129</b>   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Illinois</b> b. COUNTY <b>St Clair</b> |   |   |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <b>St Louis</b>   |  | c. LENGTH OF STAY (In this place) _____   |  | c. CITY OR TOWN <b>East St Louis</b>  |   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Saint Louis Maternity</b>  |  |   |  | e. STREET ADDRESS (If rural, give location) <b>106 1/2 North 24th Street 81208</b>  |   |   |   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) _____ b. (Middle) _____ c. (Last) <b>Hemingway</b>  |  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>July 18 1957</b> |   |   |   |   |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>Negro</b>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____  |   | 8. DATE OF BIRTH <b>July 18 1957</b>  |   |  |
| 9. AGE (In years last birthday) _____   |  | IF UNDER 1 YEAR _____   |  | IF UNDER 24 HRS. _____  |   | Hours <b>8</b> Min. <b>40</b>   |   |  |
| 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 Foreign Country) <b>St Louis Missouri</b>     |   | 12. CITIZEN OF WHAT COUNTRY? _____  |  |
| 13a. FATHER'S NAME _____  |  |   | 13b. MOTHER'S MAIDEN NAME <b>Earline Hemingway</b>           |   |   | 14. NAME OF HUSBAND OR WIFE _____   |   |  |
| 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'S SIGNATURE OR NAME <b>Earline Hemingway</b> ADDRESS <b>Above</b> |   |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.                                    |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardio respiratory arrest</b><br><br>ANTECEDENT CAUSES<br>DUE TO (b) <b>Prematurity</b><br>DUE TO (c) <b>Premature separation of placenta</b><br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 hrs</b>  |  |
| 19a. DATE OF OPERATION _____  |  | 19b. MAJOR FINDINGS OF OPERATION <b>761.5</b>   |  |   |   |   | 20. AUTOPSY? <b>Yes</b> <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 <b>July 18, 1957</b> , to <b>July 18, 1957</b> , that I last saw the deceased alive on <b>July 18, 1957</b> , and that death occurred at <b>11:45 A.M.</b> , from the causes and on the date stated above. |  |   |  |   |   |   |   |  |
| 23a. SIGNATURE <b>George Ado md.</b> (Degree or title)  |  |   |  | 23b. ADDRESS <b>457 N. Kingshighway Blvd.</b>   |   | 23c. DATE SIGNED <b>7-24-57</b>   |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) _____   |  | 24b. DATE <b>7-31-57</b>  |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>  |   | 24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>   |   |  |
| DATE REC'D BY LOCAL REG. <b>JUL 31 57</b>   |  | REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Rowland Allen</b> ADDRESS <b>4104 Manchester</b>  |   |   |   |  |

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.....  
Signature of 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**