

FILED SEP 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE NUMBER **30089**
REGISTRATION DISTRICT NO. **318** PRIMARY REGISTRATION DISTRICT NO. **1003** REGISTRAR'S NO. **7625**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS, MO.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #2.		Length of stay in lb 25 d. STREET ADDRESS 1528 COLE ST. (If outside, give location)	
3. NAME OF DECEASED (Type or print) BABY FEMALE		4. DATE OF DEATH AUG. 7, 1957	
5. SEX FEMALE		6. COLOR OR RACE NEGRO	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 7, 1957	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS THOMPSON		14. MOTHER'S MAIDEN NAME LOUISE RIVERS	
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 ST. LOUIS CITY HOSP. #1.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immature fetus Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Premature Delivery DUE TO (c) 776X			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 a. m. p. m. Month, Day, Year			
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 8/7/57 to 8/7/57 and last saw her alive on 8/7/57 Death occurred at 5:34 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE H. B. Avery M.D. (Degree or title)		22b. ADDRESS 1515 LAFAYETTE AVE.	
22c. DATE SIGNED 8/9/57			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. NAME OF CEMETERY OR CREMATORY Anatomical Board	
23c. DATE 8-31-57		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR Rowland - aka 404 Manchester ADDRESS		25. DATE RECD. BY LOCAL REG. AUG 15 57	
26. REGISTRAR'S SIGNATURE Carl Smith MO			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Seases in Part I must be carefully related. Coroner - common - country

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
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.
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.