

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

339554

STATE FILE NUMBER
9196

FILED OCT 14 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9196**

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		c. CITY OR TOWN St Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 30 Saint Louis Maternity		d. STREET ADDRESS (If outside, give location) 1270 1961 Mc Pherson Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Pappaginis		4. DATE OF DEATH Month Day Year September 13 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> Widowed	8. DATE OF BIRTH September 13 1957
9. AGE (In years last birthday) 7		IF UNDER 1 YEAR Months 20	IF UNDER 24 HRS. Hours 7 Min. 20
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) St Louis Missouri
12. CITIZEN OF WHAT COUNTRY? --		13a. FATHER'S NAME Philip Pappaginis	
13b. MOTHER'S MAIDEN NAME Nicke Ginnous		14. NAME OF HUSBAND OR WIFE --	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --	17. INFORMANT Address Nicke Pappaginis Above
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Immaturity incompatible w life Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) 776x DUE TO (c) 776x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Large teratoma attached to roof of baby's mouth			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 a.m. Month, Day, Year 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 September 13 1957 to September 13 1957 and saw her alive on Sept 13 1957 Death occurred at 4:00 P M on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Describe or title) Roman K. Muschauer M.D.		22b. ADDRESS St. Louis Maternity Hospital	
22c. DATE SIGNED 9-20-57		23a. BURIAL, CREMATION, REMOVAL (Specify) OCT 31 57	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
23d. LOCATION (City, town, or county) (State) St. Louis, Mo.		24. FUNERAL DIRECTOR ADDRESS Rowland Ake 4104 Mansfield	
25. DATE RECD. BY LOCAL REG. OCT 2 '57		26. REGISTRAR'S SIGNATURE Paul Smith MD	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.