

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37131

STATE FILE NUMBER

FILED OCT 25 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.
9664

Health,
Welfare
Public
Service

300
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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>E. St. Louis</u> 812 ⁸ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>39 Cardinal Glennon</u> Length of stay in lb <u>3 days</u>		d. STREET ADDRESS (If outside, give location) <u>32 4614 Gay</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Darryl</u> First Middle Last <u>AVANT</u>		4. DATE OF DEATH <u>10-13-57</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-7-37</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	9c. AGE (In years last birthday) <u>0</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>6</u> Hours <u></u> Min. <u></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>Infant</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo</u>
13. FATHER'S NAME <u>Walter Avant</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>Beatrice McWhorter</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Walter Avant</u> Address <u>4614 Gay</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GANGLIENE OF SMALL BOWEL WITH PERFORATION + PNEUMONIA</u> DUE TO (b) <u>THROMBOCYTOPENIC PURPURA</u> DUE TO (c) <u>296x</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 <u>3 days</u>
19a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	200. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>			
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 <u>11 Oct 57</u> to <u>13 Oct 57</u> and last saw <u>him</u> alive on <u>10-13-57</u> . Death occurred at <u>6:30 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. J. Depatrel M.D.</u>		22b. ADDRESS <u>1465 J. Grand</u>	
22c. DATE SIGNED <u>10/16</u>			
22d. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-16-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Booker Washington</u>	23d. LOCATION (City, town or county) (State) <u>E. St. Louis, Ill.</u>
24. FUNERAL DIRECTOR <u>C.T. Nash Funeral Home</u> ADDRESS <u>111 N. 13th</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 16 57</u>	
26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 *M. Arnesen*
Licensed Embalmer No. *443*

P. O. Address *3847*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.