t. Health,
, & Welfare
S. Public
th Service

. S. 300 0
v. 1-57

FILED OCT 30 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 37797

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9927

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE b. COUNTY

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST. LOUIS, MO. Inside Limits Yes ☐ No ☐

c. CITY OR TOWN ST. LOUIS, MO. Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 25 ST. LOUIS CITY HOSP. #1. Length of stay in 1b

d. STREET ADDRESS 2 923 RUTGER (If outside, give location) Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First BABY(KATHLEEN) Middle Last MC COY

4. DATE OF DEATH Month Day Year OCT. 18, 1957

5. SEX FEMALE 3

6. COLOR OR RACE NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 10/7/57

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days 11 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE

10b. KIND OF BUSINESS OR INDUSTRY NONE

11. BIRTHPLACE (City and state or country) ST. LOUIS, MO. 0

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME JOE MC COY

13b. MOTHER'S MAIDEN NAME ELIZABETH DAVIS

14. NAME OF HUSBAND OR WIFE NONE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) NO

16. SOCIAL SECURITY NO. NO

17. INFORMANT ST. LOUIS CITY HOSP. #1. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Insufficiency

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Immature Birth

DUE TO (c)

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) 773.5

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 10/7/57, to 10/18/57 and last saw her/him alive on 10/18/57

Death occurred at 10:30 A.M m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] M.D. 0

22b. ADDRESS 1515 LAFAYETTE AVE.

22c. DATE SIGNED 10/22/57

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE 10-31-57

23c. NAME OF CEMETERY OR CREMATORY Anatomical Board

23d. LOCATION (City, town, or county) St. Louis, Mo. (State)

24. FUNERAL DIRECTOR Rowland-Aker ADDRESS 4104 Manchester

25. DATE RECD. BY LOCAL REG. OCT 24 '57

26. REGISTRAR'S SIGNATURE Earl Smith Mo

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 ..... Signed .....
Signature of Student Embalmer

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.