

FILED NOV 15 1957

STANDARD CERTIFICATE OF DEATH

38018

Registration District No. 318 Primary Registration District No. 1003 STATE FILE NUMBER 10563

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		c. CITY OR TOWN <u>ST. LOUIS, MO.</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1.</u>		d. STREET ADDRESS (If outside, give location) <u>2809 DAYTON</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY GIRL RANCHER</u>		4. DATE OF DEATH Month Day Year <u>OCT. 31, 1957</u>	
5. SEX <u>FEMALE</u> <u>3</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>10/30/57</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>NONE</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO.</u>
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>LONNIE MAE RNCHEER</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>ST. LOUIS CITY HOSP. #1.</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>Senaturity</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ 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>776x</u>
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. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>10/30/57</u> to <u>10/31/57</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>10/31/57</u> Death occurred at <u>3:A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>William T. Gleason M.D.</u>		22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>	22c. DATE SIGNED <u>11/1/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-30-57</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR <u>Rowland Aker 404 Manchester</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 7 '57</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 .....

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.