

Dept. Health,
r. & Welfare
S. Public
alth Service

V. S. 300
ev. 1-57

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

FILED DEC 9 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

42219
STATE FILE NUMBER
10850
Registrar's No.

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> COUNTY <i>St. Louis</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis Mo</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>University City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>14 Jewish Hospital</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>27 1445 Pentridge</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Baby</i> Middle _____ Last <i>Kling</i>			4. DATE OF DEATH Month <i>Oct</i> Day <i>5</i> Year <i>1957</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 5, 1957</i>	9. AGE (In years last birthday) <i>20</i>	IF UNDER 1 YEAR Months _____ Days _____
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) <i>St. Louis Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13a. FATHER'S NAME <i>Merle Kling</i>		13b. MOTHER'S MAIDEN NAME <i>Ann Yaeger</i>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <i>Hospital Records</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atelectasis</i>					INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <i>Massive anasarca</i>					
DUE TO (c) <i>Erythroblastosis fetalis</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Prematurity</i>					19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> 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 <i>10:30 PM</i> to <i>10:30 PM</i> last saw him alive on <i>Oct 5, 1957</i> Death occurred at <i>10:30</i> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Bernice A. Torin, m. 8</i> (Degree or title)			22b. ADDRESS <i>462 N. Taylor</i>		22c. DATE SIGNED <i>Oct. 7 1957</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>11-30-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis Mo.</i>	
24. FUNERAL DIRECTOR <i>Rowland - Aker 4104 Manchester</i> ADDRESS		25. DATE RECD. BY LOCAL REG. <i>NOV 14 '57</i>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

(Licensed Embalmer's Statement on Reverse Side)

mxs

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.