

V. S. N. 300
REV. 10-48

THE DIVISION OF HEALTH OF MISSOURI

FILED DEC 11 1957 STANDARD CERTIFICATE OF DEATH

State File No. **43055**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **3000**

46010

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before adjustment.) a. STATE Missouri b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Normandy		c. LENGTH OF STAY (in this place) 14 hrs.	c. CITY OR TOWN St. Louis		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 443 Normandy Osteopathic Hospital			e. STREET ADDRESS (If rural, give location) 4926 Rosalie		
3. NAME OF DECEASED (Type or Print) a. (First) Baby Girl c. (Last) Geldien		4. DATE OF DEATH (Month) (Day) (Year) 11 28 57			
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 11-28-57	9. AGE (In years last birthday) 15	IF UNDER 1 YEAR Months _____ Days _____
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 Foreign Country) St. Louis Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Lowell Geldien		13b. MOTHER'S MAIDEN NAME Carol Medlock		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Lowell R. Helms ADDRESS _____			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Immaturity DUE TO (c) 773.5				INTERVAL BETWEEN ONSET AND DEATH 14 hours
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/28 , 19 57 , to 11/28 , 19 57 , that I last saw the deceased alive on 11/28 , 19 57 , and that death occurred at 4:25 P. M. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Jay A. Kilpatrick, D.O.			23b. ADDRESS 4601A Pope Ave St. Louis 15		23c. DATE SIGNED 11/28/57
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 11/28/57	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo		
DATE REC'D BY LOCAL REG 11-29-57	REGISTRAR'S SIGNATURE Hubert R. Donkema		25. FUNERAL DIRECTOR'S SIGNATURE Stanley L. ...		ADDRESS 1150 N. ...

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. 2930

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.