

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007164

STATE FILE NUMBER

FILED FEB 28 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1955

300
-57

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)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Saint Louis Maternity				Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 926 Bayard Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Dunlap				4. DATE OF DEATH Month Day Year February 2 1958			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 1 1958	
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)		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Lee Pulevin Dunlap		13b. MOTHER'S MAIDEN NAME Pearlie Mae Deberry		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 Pearlie Mae Dunlap Address above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Atelectasis							
DUE TO (c) Prematurity						76 2/5	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hydro nephros, hydro ureter, bilateral with dilatation of urinary bladder						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
20e. CITY, TOWN, OR LOCATION			20f. COUNTY		20g. STATE		
21. I attended the deceased from February 1 1958 to February 2 1958 and last saw ^{her} / _{him} alive on February 2 1958			Death occurred at 12:05 A M on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (D, M, or title) Norman K. Muschany M.D.			22b. ADDRESS St. Louis Maternity Hospital			22c. DATE SIGNED 2-4-58	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-28-58		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR Rowland Aker 410 Manchester			25. DATE RECD. BY LOCAL REG. FEB 14 '58		26. REGISTRAR'S SIGNATURE Paul Smith MD <i>mjs</i>		

Doctor, coroner, etc. must use only standard nomenclature in item 18. 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.