Health, Welfare Public Service

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FILED MAR 5 - 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH 12558-58

58-007687
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2358

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN ST. LOUIS, MO. — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1. — Length of stay in Ib 25	d. STREET ADDRESS 618 Withers (If outside, give location) ~~ST. LOUIS CITY HOSP. #1~~ — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First BABY	Middle GIRL	Last PREWITT	4. DATE OF DEATH Month FEB. Day 1, Year 1958
5. SEX girl	6. COLOR OR RACE WHITE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH FEB. 1, 1958	9. AGE (In years if last birthday) — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours 3, Min. 35
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 CITY HOSP. #1. ST. LOUIS MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME BURL PREWITT	13b. MOTHER'S MAIDEN NAME MAXINE HALL	14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	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) Prematurity

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

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) 776X

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 2/1/58, to 2/1/58 and last saw her/him alive on 2/1/58

Death occurred at 7:40 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William T. Atkinson Jr. M.D.

22b. ADDRESS 1515 LAFAYETTE AVE.

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) St. Louis, (State) Mo.

24. FUNERAL DIRECTOR Rowland-Aker ADDRESS 4104 Manchester

25. DATE RECD. BY LOCAL REG. FEB 27 '58

26. REGISTRAR'S SIGNATURE Karl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

BIRTH # 3180

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.