Health, Welfare Public Service

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FILED APR 3 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

19784-58

58-012011

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3528

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 30 Saint Louis Maternity — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 219 3034 Cass Avenue — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle 0 Last Means

4. DATE OF DEATH Month March Day 19 Year 1958

5. SEX Female 3

6. COLOR OR RACE Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ 0 DIVORCED ☐

8. DATE OF BIRTH March 18 1958

9. AGE (In years last birthday) — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours 20 Min. 25

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) St Louis Missouri 0

12. CITIZEN OF WHAT COUNTRY? -

13a. FATHER'S NAME Edward John Means

13b. MOTHER'S MAIDEN NAME Lucy Mae Lindsey

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 Lucy Mae Means — Address Above

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) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH 20 hr. - 25 min

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

DUE TO (c) 762.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Subarachnoid hemorrhage

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 March 18 1958, to March 19 1958 and last saw her/him alive on March 19 1958

Death occurred at 1:25 P M m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Norman K. Mersheim M.D. 0

22b. ADDRESS St. Louis Maternity Hospital

22c. DATE SIGNED 3-23-58

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE 3-31-58

23c. NAME OF CEMETERY OR CREMATORY Anatomical Board

23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR Rowland-Aker — ADDRESS 4104 Manchester

25. DATE RECD. BY LOCAL REG. MAR 28 '58

26. REGISTRAR'S SIGNATURE J. Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms without reference to the disease. 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.