Health, Welfare Public Service

FILED APR 21 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

29034-58

58-016687
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1067

1. PLACE OF DEATH
a. COUNTY: St. Louis County
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Clayton, — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Louis County Hosp. — Length of stay in Ib: 16HR. 10MIN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Fenton 4000 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): R.R.#1 — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: BABY Middle: Boy Last: GUIBOR

4. DATE OF DEATH: Month 4 Day 11 Year 1958

5. SEX: male 0

6. COLOR OR RACE: white

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [ ] 0 **DIVORCED** [ ]

8. DATE OF BIRTH: 4-11-58

9. AGE (In years last birthday): IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours 16 Min. 10

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): Clayton, Mo. 0

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Alvin Guibar

13b. MOTHER'S MAIDEN NAME: Hazel Radcliff

14. NAME OF HUSBAND OR WIFE: NONE

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.: none

17. INFORMANT: St. Louis County Hospital, Clayton, Mo. Address

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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): HEART FAILURE
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): PULMONARY IMMATURITY
DUE TO (c): Premature Birth 7735
INTERVAL BETWEEN ONSET AND DEATH: from Birth
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

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 4-11-1958 to 4-11-1958 and last saw her/him alive on 4-11-1958
Death occurred at 805 p.m. on the date stated above; and to the best of my knowledge, from the causes stated. 4-15-58

22a. SIGNATURE: [signature] (Degree or title) MD 0

22b. ADDRESS: 601 S. BRENTWOOD BLVD.

22c. DATE SIGNED: 4-15-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE: 4-17-58

23c. NAME OF CEMETERY OR CREMATORY: Mo. Crematory

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

24. FUNERAL DIRECTOR: St. L. Co. Hosp. ADDRESS: Clayton

25. DATE RECD. BY LOCAL REG.: 4-17-58

26. REGISTRAR'S SIGNATURE: Herbert R. Domke M.D.

(Licensed Embalmer's Statement on Reverse Side)

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.