

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023096
State File No.

48-00-57
FILLED JUL 3 1958

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 6357

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jefferson	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN) St. Louis, Mo.		c. LENGTH OF STAY (in this place) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION 24 St. Louis Children's Hospital		c. CITY OR TOWN Hillsboro	
3. NAME OF DECEASED (Type or Print) a. (First) Clinton b. (Middle) Clyde c. (Last) Baldwin		4. DATE OF DEATH (Month) (Day) (Year) 6 21 58	
5. SEX M O W	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) O	8. DATE OF BIRTH 6-19-58
9. AGE (in years last birthday) 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	
11. BIRTHPLACE (City and State or Foreign Country) Hillsboro, Ma		12. CITIZEN OF WHAT COUNTRY? O G.S.A.	
13a. FATHER'S NAME Wm Clyde Baldwin		13b. MOTHER'S MAIDEN NAME Harriet Ross	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) —	
16. SOCIAL SECURITY NO. —		17. INFORMANT'S SIGNATURE OR NAME B. Finneran	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhagic pneumonia ANTECEDENT CAUSES Meningitis, Myelitis, rising fever, acute cause (a) stating the underlying cause last DUE TO (c) 6/24/58 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Subarachnoid hemorrhage	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 7630	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		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)		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 June 21, 1958, to June 21, 1958, that I last saw the deceased alive on June 21, 1958 and that death occurred at 5:01p m., from the causes and on the date stated above.			
23a. SIGNATURE Barbara Jones, M.D.		23b. ADDRESS 500 S. Kingshighway	
23c. DATE SIGNED 6-21-58		23d. LOCATION (City, town, or county) (State) Hillsboro Ma	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-21-58	
24c. NAME OF CEMETERY OR CREMATORY Hillsboro Cem.		24d. LOCATION (City, town, or county) (State) Hillsboro Ma	
DATE REC'D BY LOCAL REG. JUN 23 1958		REGISTRAR'S SIGNATURE J. Carl Smith MD	
25. FUNERAL DIRECTOR'S SIGNATURE MANN FUNERAL HOME		ADDRESS Desoto, Mo	

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 *Laurie J. Mal...*

Licensed Embalmer No. *432*

P. O. Address *Alb...*

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.