

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023975

STATE FILE NUMBER

FILED JUL 11 1958

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1734

S. 300
1-57
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1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>						
b. CITY OR TOWN <u>Clayton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Blumay 4870</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Co. Hosp</u>			Length of stay in 1b <u>1 HR.</u>		d. STREET ADDRESS (If outside, give location) <u>1202nd Wachtel</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Girl Peters</u>				4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1958</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-23-58</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>60</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>Clayton, Missouri, USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Robert Peters</u>			13b. MOTHER'S MAIDEN NAME <u>Dean Wooten</u>			14. NAME OF HUSBAND OR WIFE <u>NONE</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>St. Louis County Hospital, Clayton Mo</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis</u>							INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Prematurity</u>		DUE TO (c) <u>762.5</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hepatic, adrenal, & cerebral hemorrhage</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 _____ a.m. _____ p.m.			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			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 <u>6-23-1958</u> to <u>6-25-1958</u> and last saw her alive on <u>6-25-1958</u> Death occurred at <u>6-25-1958</u> <u>8:40 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			22a. SIGNATURE (Degree or title) <u>Vincent L. Fredrick M.D.</u>			22b. ADDRESS <u>601 S. Brentwood Clayton</u>			22c. DATE SIGNED <u>6-27-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>6-30-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MISSOURI CREMATORY</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>				
24. FUNERAL DIRECTOR ADDRESS <u>ST LOUIS COUNTY HOSP. CLAYTON, MO</u>				25. DATE RECD. BY LOCAL REG. <u>6-30-58</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Danke M.D.</u>				

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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.