

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

69470-58

58-030951

STATE FILE NUMBER

8230

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8230

FILED SEP 15 1958

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN LeMay 4860.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hosp. 0		Length of stay in lb 6 days	d. STREET ADDRESS (If outside, give location) 27 825 Tennessee
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Pamela Lynn Senseney			4. DATE OF DEATH Month Day Year August 22 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1958	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 6	
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 Missouri 0		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James Senseney		13b. MOTHER'S MAIDEN NAME Mary Grey		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address James Senseney 825 Tennessee, St. Louis		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congenital atelectasis of the lung. prematurity (6½) mos gestation		INTERVAL BETWEEN ONSET AND DEATH 1 week.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7625		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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 Month, Day, Year 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 August 15 to August 22 and last saw her alive on August 22 58 Death occurred at August 22 on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE John G. Kellett (Name or title)	22b. ADDRESS 2314 Telegraph Rd.	22c. DATE SIGNED 8-23-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE August 25, 1958	23c. NAME OF CEMETERY OR CREMATORY Jefferson Bks. National Cem.	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Missouri
24. FUNERAL DIRECTOR C. Hoffmeister Mortuary 7814 S. Broadway St. Louis Missouri	25. DATE RECD. BY LOCAL REG. AUG 25 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith, MD S.P.	

Donor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Not embalmed*
Rice C. Hanson

Licensed Embalmer No. *4764*

P. O. Address *St. Louis*

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.