

Health, Welfare Public Service 66 300 1-56
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-037691

STATE FILE NUMBER

10403

FILED NOV 10 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar No. 10403

| | | | |
|---|------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>1</i> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <i>St. Louis Mo</i> Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>North = 2</i> Length of stay in 1b | | 3. STREET ADDRESS (If outside give location) <i>1117 Mo. Avenue 27</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Baby Collins</i> | | 4. DATE OF DEATH <i>10 17 58</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Cauc</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>10 10 58</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>House</i> | 11. BIRTHPLACE (City and state or country) <i>Mo. Va.</i> |
| 13. FATHER'S NAME <i>Wick</i> | | 14. MOTHER'S MAIDEN NAME <i>Wick</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give branch and dates of service) <i>Wick</i> | | 16. SOCIAL SECURITY NO. <i>Wick</i> | 17. INFORMANT <i>W. Taylor Co. 1300 Clark</i> Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital Ophthalmocelc</i> | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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) <i>560.2</i> | | | 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 Month, Day, Year a. m. p. m. | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <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 <i>1/15</i> to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>James M. Kelly</i> (Degree or title) <i>Deputy Coroner</i> | | 22b. ADDRESS <i>1300 Clark</i> | 22c. DATE SIGNED <i>10-18-58</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <i>OCT 3 1'58</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i> | 23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i> |
| 24. FUNERAL DIRECTOR <i>Rowland-Aker Mortuary Service</i> ADDRESS <i>4104 Manchester Ave.</i> | | 25. DATE RECD. BY LOCAL REG. <i>OCT 3 1'58</i> | 26. REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.