

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046333
STATE FILE NUMBER

97130-58
FILED JAN 14 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12798

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS, MO.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 2622 DAYTON	
3. NAME OF DECEASED (Type or print) First BABY GIRL Middle SMITH Last SMITH		4. DATE OF DEATH Month DEC. Day 27, Year 1958			
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/58	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 2 Days
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, MO	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME ROSIE MARIE SMITH	
14. NAME OF HUSBAND OR WIFE		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 ST. LOUIS CITY HOSP, #1.		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) Anoxia DUE TO (b) Congenital Atelectasis DUE TO (c) Prematurity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 2					INTERVAL BETWEEN ONSET AND DEATH
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.) 762.5			
20c. TIME OF INJURY Hour 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 12/25/58 to 12/27/58 and last saw her alive on 12/27/58 Death occurred at 8:05 A. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Edward M. White M.D.</i>		22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 12/29/58	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-31-59		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
23d. LOCATION (City, town, or county) St. Louis, Mo.		(State)			
24. FUNERAL DIRECTOR Rawlond Lee 4104 Manchester		ADDRESS		25. DATE RECD. BY LOCAL REG. JAN 8 '59	
26. REGISTRAR'S SIGNATURE <i>Carl Smith MO</i>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.