

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-047259
State File No.

FILED JAN 19 1959

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 12801

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 <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>32 ST. LUKE'S HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>27 6th Marshall</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>BABY</u> b. (Middle) _____ c. (Last) <u>MC CABE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12 16 58</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>12-16-58</u>
9. AGE (In years last birthday) _____	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>JOSEPH E. McCABE</u>		13b. MOTHER'S MAIDEN NAME <u>ELSIE MARIE JOHNSON</u>	
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>JOSEPH E. McCABE</u> ADDRESS <u>620 MARSHALL VALLEY PARK MO</u>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Anoxia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Abruptio placentae</u> DUE TO (c) <u>761.0</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (STATE) <u>St. Louis Mo</u>	
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? <u>see 18</u>	
22. I hereby certify that I attended the deceased from <u>12-16-58</u> , to <u>12-16-58</u> , that I last saw the deceased alive on <u>12-16-58</u> , and that death occurred at <u>10:00</u> a.m., from the causes and on the date stated above.			
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>5335 Delmar Plaza</u>	23c. DATE SIGNED <u>Dec. 18</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) _____	24b. DATE <u>1-31-59</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
DATE REC'D BY LOCAL REG. <u>JAN 8 59</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>4104 Manchester</u>	

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.