THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002877

STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 448

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☑ No ☐	c. CITY OR TOWN 2019 St. Louis — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St Anthonys — Length of stay in 1b 2 DAYS	d. STREET ADDRESS (If outside, give location) 7147 Virginia — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First CARL Middle Last DONALD		4. DATE OF DEATH Month Jan Day 12 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH Mch. 13 1958
9. AGE (In years last birthday) 00	IF UNDER 1 YEAR Months 10 Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St Louis Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Everett Donald		14. MOTHER'S MAIDEN NAME Betty Leel	
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. No	17. INFORMANT Everett Donald Address 7147 Virginia	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STATUS ASTHMATICUS c̄ Rt. heart FAILURE — INTERVAL BETWEEN ONSET AND DEATH 12 HRS.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ..... DUE TO (c) 241X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BILATERAL BRONCHOPNEUMONIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 BIRTH, to 1/12/59 and last saw her/him alive on 1/11/59

Death occurred at 7:15 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Charles B Lane MD	22b. ADDRESS 7430 Virginia Ave	22c. DATE SIGNED 1/13/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-15-1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive	23d. LOCATION (City, town, or county) (State) St Louis Co. Mo.
24. FUNERAL DIRECTOR Jos. P. Fendler Jr.	ADDRESS 7128 Michigan	25. DATE RECD. BY LOCAL REG. JAN 14 '59	26. REGISTRAR'S SIGNATURE J. Earl Smith M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

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 e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Gustav H. Gute

Licensed Embalmer No. 4

P. O. Address St. Lou

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.