

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003742
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 295

1. PLACE OF DEATH
a. COUNTY St. Louis County
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton Inside Limits Yes No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. Louis County Hospital Length of stay 6 1/2 hr
d. STREET ADDRESS (If outside, give location) 23 Reading Reside on Farm Yes No

3. NAME OF DECEASED First Baby Middle Girl Last Moritz
4. DATE OF DEATH Month 1 Day 25 Year 1959

5. SEX Female **6. COLOR OR RACE** White **7. MARRIED** NEVER MARRIED **8. DATE OF BIRTH** 1-29-59 **9. AGE (In years last birthday)** 6 **IF UNDER 1 YEAR** Months 6 Days 15 **IF UNDER 24 HRS.** Hours 6 Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **10b. KIND OF BUSINESS OR INDUSTRY** **11. BIRTHPLACE** (City and state or country) Missouri **12. CITIZEN OF WHAT COUNTRY?** USA

13a. FATHER'S NAME William G. Moritz **13b. MOTHER'S MAIDEN NAME** Patsy Nakasato **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) **16. SOCIAL SECURITY NO.** **17. INFORMANT** County Hosp. Record Room Address 776x

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Immaturity (570 Gms.) 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)

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 1-25-1959 to 1-25-1959 and last saw her alive on 1-25-1959
Death occurred at 4:35 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. H. Harrison, Jr. M.D. **22b. ADDRESS** 601 S. Brentwood Blvd. **22c. DATE SIGNED** 1-26-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal **23b. DATE** 1-30-59 **23c. NAME OF CEMETERY OR CREMATORY** Mo. Crematory **23d. LOCATION** (City, town, or county) (State) St. Louis Mo.

24. FUNERAL DIRECTOR ADDRESS County Hospital Clayton, Mo. **25. DATE RECD. BY LOCAL REG.** 1-30-59 **26. REGISTRAR'S SIGNATURE** John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300
-57

FILED FEB 10 1959

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.