THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003851
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 317 Primary Registration District No. 547 Registrar's No. 29

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

1. PLACE OF DEATH
a. COUNTY: ST. LOUIS
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): RICHMOND HGTS — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ST. MARYS HOSP. — Length of stay in Ib: 6 HRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO — b. COUNTY: ST. LOUIS
c. CITY OR TOWN: ST. LOUIS 37 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 4000 10228 GOUROCK DR — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: INFANT — Middle: JAMES — Last: CROWE

4. DATE OF DEATH: Month: 1 — Day: 3 — Year: 59

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: 1-2-59

9. AGE (In years last birthday): — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 6 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): RICHMOND HGTS MO

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13a. FATHER'S NAME: JAMES CROWE

13b. MOTHER'S MAIDEN NAME: BERNETTA-SCHWEITZER

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): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT — Address: JAMES CROWE-10228-GOUROCK DR.

MEDICAL CERTIFICATION

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

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Atelectasis	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. — DUE TO (b)	Prematurity 26-28 wks gestation	6 hrs.
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 7625

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

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 1-2-59, to 1-3-59 and last saw her/him alive on 1-3-59
Death occurred at 7:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): E. J. Bechetti M.D.

22b. ADDRESS: 4500 Olive St. (8)

22c. DATE SIGNED: 1-3-59

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: 1-5-59

23c. NAME OF CEMETERY OR CREMATORY: CALVARY CEM

23d. LOCATION (City, town, or county): ST. LOUIS — (State): MO

24. FUNERAL DIRECTOR — ADDRESS: JAY B. SMITH - MAPLEWOOD 17 MO.

25. DATE RECD. BY LOCAL REG.: 1-5-59

26. REGISTRAR'S SIGNATURE: Herbert R. Clark, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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.

NOT EMBALMED -/-
H.W. BROWN.

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.