

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011031

STATE FILE NUMBER
2-3158

FILED APR 10 1959

Registration District No. _____ Primary Registration District No. _____

Registrar's No. _____

300
1-57
36
74

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL INSTITUTION St. Louis Childrens		d. STREET ADDRESS 3109 Kimberly (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Casandra Louise Hudson		4. DATE OF DEATH Month Day Year 3 27 59	
5. SEX Female ³	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-59
9. AGE (In years last birthday) 9		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (City and state or country) St. Louis, Mo. 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Clyde Hudson	
14. MOTHER'S MAIDEN NAME Quincy Pettis		15. NAME OF HUSBAND OR WIFE None	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, NO unknown) (If yes, give branch and date of service)		17. SOCIAL SECURITY NO. None	18. INFORMANT Luan Lehr, 500 S. Kingshighway 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) Prematurity with fetal atelectasis DUE TO (b) _____ DUE TO (c) IV Septal defect 762.5 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Duodenal stenosis - operative repair on 3 rd day of life			INTERVAL BETWEEN ONSET AND DEATH 1 hr
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year 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 4:03 p. to 3-23-59 and last saw her alive on 3-27-59 Death occurred at 4:03 p. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Richard Smith M.D.	
22b. ADDRESS 500 S. Kingshighway		22c. DATE SIGNED 3-27-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/31/59	23c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR G. Wade Oranberry 4202 Finney Avenue		25. DATE RECD. BY LOCAL REG. MAR 30 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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 *Edward A Flynn*

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave

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.