

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015377

STATE FILE NUMBER

2 3983

FILED MAY 6 1959 Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO.		c. CITY OR TOWN ST. LOUIS, MO.	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP #1.		d. STREET ADDRESS 133 8 a CLARA	

3. NAME OF DECEASED (Type or print) First Middle Last FREDRICK MCQUINN			4. DATE OF DEATH Month Day Year APRIL 14, 1959		
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5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/59	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME FREDRICK MCQUIN	13b. MOTHER'S MAIDEN NAME ARTHERINE BATES	14. NAME OF HUSBAND OR WIFE
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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. none	17. INFORMANT Address ST. LOUIS CITY HOSP. #1.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Atelectasis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pre maturity		
DUE TO (c) 762.5		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 4/13/59 to 4/14/59 and last saw her/him alive on 4/14/59 Death occurred at 11:35 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) W. W. McQuinn M.D.	22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 4/14/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) 4-30-59	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR ADDRESS Lowland Aker 4104 Manchester	25. DATE RECD. BY LOCAL REG. APR 23 '59	26. REGISTRAR'S SIGNATURE Roald Smith M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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.