

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015494

STATE FILE NUMBER

FILED MAY 1 1959

Registration District No.

Primary Registration District No.

Registration No. 3628

1. PLACE OF DEATH a. COUNTY Nil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Nil	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hosp		Length of stay in 1b D.O.A.	d. STREET ADDRESS (If outside, give location) 6132 Westminster Pl.
3. NAME OF DECEASED (Type or print) First Middle Last Nancy Ann Norton			4. DATE OF DEATH Month Day Year 4 II '59.
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Mar. 16, '59	9. AGE (In years last birthday) IF UNDER 1 YEAR Months 25
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?
13a. FATHER'S NAME David L. Norton		13b. MOTHER'S MAIDEN NAME Joan M. Carter	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 David L. Norton 6132 Westminster Pl., St. Louis, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Interstitial Pneumonitis</i>			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)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) 7630		
20c. TIME OF INJURY Hour Month, Day, Year a.m. 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 _____ to _____ and last saw her alive on _____ Death occurred at _____ 1005 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Patric L. Taylor</i> (Degree or title)		22b. ADDRESS 300 Clark	22c. DATE SIGNED Apr 15 1959
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-14, '59.	23c. NAME OF CEMETERY OR CREMATORY Resurrection	23d. LOCATION (City, town, or county) (State) St. Louis Mo
24. FUNERAL DIRECTOR MITTELBERG	ADDRESS Webster Groves Mo.	25. DATE RECD. BY LOCAL REG. APR 13 '59	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> M. J. B.

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

Mittelberg Funeral Home.
P. J. Klamberg
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.

Not Embalmed