

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015866
STATE FILE NUMBER

FILED APR 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. **3516**

300
1-57
391

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
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 Hospital		d. STREET ADDRESS 2721 Henrietta St. ST. LOUIS, MO	
3. NAME OF DECEASED (Type or print) First KATHY Middle MARIE Last TRIPP		4. DATE OF DEATH Month MARCH Day 29 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/29/59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or county) ST. LOUIS, MO
13a. FATHER'S NAME CHARLES C TRIPP		13b. MOTHER'S MAIDEN NAME CHELENE SMITH	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) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address ST. LOUIS CITY HCSP. #1.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia DUE TO (b) Immaturity 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)			INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
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.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <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 3/29/59 , to 3/29/59 and last saw ^{her} _{him} alive on 3/29/59 Death occurred at 6:10 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Leo J. Mulligan, M.D.		22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 3/30/59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4-30-59	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR ADDRESS Rowland-Weev 4104 Manchester		25. DATE RECD. BY LOCAL REG. APR 9 '59	26. REGISTRAR'S SIGNATURE Leo J. Mulligan, M.D. <i>mjb</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

2721 Henrietta

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.