

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

59-016068

STATE FILE NUMBER

FILED MAY 8 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1243

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Webster Groves</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Co. Hosp</u>		Length of stay in 1b <u>35 HRS.</u>	d. STREET ADDRESS (If outside, give location) <u>424 N. Elm</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy Lennox</u>			4. DATE OF DEATH Month Day Year <u>4-16-59</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-59</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years last birthday) F UNDER 1 YEAR Months Days <u>35</u> IF UNDER 24 HRS. Min. <u>35</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Clayton, Mo. U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Unknown</u>	
13b. MOTHER'S MAIDEN NAME <u>Lula Lennox</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>St. Louis County Hospital</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u>			INTERVAL BETWEEN ONSET AND DEATH <u>35 hours</u>
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) <u>776x</u>			
19. WAS AUTOPSY PERFORMED? 1 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.)		
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 <u>4-15-59</u> to <u>4-16-59</u> and last saw ^{her} him alive on <u>4-16-59</u> Death occurred at <u>11:18 a.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Leonard Peter Rome M.D.</u>		22b. ADDRESS <u>601 S. Brentwood</u>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>4/18/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MO CREMATORY</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>ST LOUIS COUNTY HOSP CLAYTON</u>		25. DATE RECD. BY LOCAL REG. <u>5-5-59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.