

FILED JUL 3 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023188

State File No.

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. **2 5621**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO		b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis (15)		c. CITY (If outside corporate limits, write RURAL and give township) 448 Jennings (20)		d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 5534 Hadisment Ave		3. NAME OF DECEASED a. (First) Infant	
b. (Middle) girl		c. (Last) Meeker		4. DATE OF DEATH (Month) (Day) (Year) 6-11-1959	
5. SEX Female	6. COLOR OR RACE W-	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH 6-11-1959	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis (15) Mo.	12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Cerald Edwin Meeker		13b. MOTHER'S MAIDEN NAME Norine Mary Michels		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.		17. INFORMANT'S SIGNATURE OR NAME Cerald E. Meeker	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Congenital Anomalie			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____			_____
DUE TO (c) no Paronyx - no Rt Kidney + no Rt Urterae		_____			_____
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		_____			_____
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION See Autopsy			20. AUTOPSY? / YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Missouri		21d. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		759.3		
22. I hereby certify that I attended the deceased from 6-11, 1959 to 6-11, 1959 , that I last saw the deceased alive on 6-11, 1959 , and that death occurred at 12:50 p.m. , from the causes and on the date stated above.					
23a. SIGNATURE Anthony J. Vitale M.D.		23b. ADDRESS 7130 Natural Bridge Rd		23c. DATE SIGNED 6/12/59	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 12, 1959	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. JUN 12 '59	REGISTRAR'S SIGNATURE Stan Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE E.J. Schnur		
			ADDRESS 3125 Lafayette Ave.		

(Licensed Embalmer's Statement on Reverse Side)

S. P.

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
Student Embalmer

Signed _____

No Embalming

Licensed Embalmer No. _____

P. O. Address _____

William Volmer

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.