

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-026550
State File No.

FILED VS JUL 30 1959

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. **2 6834**

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis	c. LENGTH OF STAY (In this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Booth Memorial Hospital		d. STREET ADDRESS (If rural, give location) 3338 Ohio	

3. NAME OF DECEASED (Type or Print) Infant	a. (First) _____	b. (Middle) _____	c. (Last) DePriest	4. DATE OF DEATH (Month) (Day) (Year) 7 14 59
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH July 14, 1959	9. AGE (In years last birthday) (Months) (Days) (Year) 1 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis Missouri		12. CITIZEN OF WHAT COUNTRY? USA.

13a. FATHER'S NAME Kenneth DePriest	13b. MOTHER'S MAIDEN NAME Sylvia Norman	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)	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Kenneth J. DePriest	ADDRESS _____
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH life
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Atelectasis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Immature 1 lbs 8 oz.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 762.5			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **July 14, 1959**, to _____, 19____, that I last saw the deceased alive on **July 14, 1959**, and that death occurred at **7:33 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Leroy Ellison M.D.	23b. ADDRESS 36108 Broadway St. Louis Mo	23c. DATE SIGNED 7/14/59
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 7-31-59	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. III 23 59	REGISTRAR'S SIGNATURE Loan Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Rawland Aker	ADDRESS 404 Manchester
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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249.2

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

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