RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–030355

FILED VS SEP 1 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7729 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3112 Sheridan
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Middle: Last: Douthit

4. DATE OF DEATH: Month 8 Day 11 Year 59

5. SEX: Fem.

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8-11-59

9. AGE (last birthday) IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours 2 Min. 44

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 country): Saint Louis, Missouri

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: ~

13b. MOTHER'S MAIDEN NAME: Myrtle Douthit

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: Hospital Records Address: 2601 N. Whittier

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Premature birth, Neonatal death
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 773.5
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☑ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 8-11-59, to 8-11-59 and last saw her alive on 8-11-59
Death occurred at 5:10 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Paul White, MD

22b. ADDRESS: 2601 N. Whittier

22c. DATE SIGNED: 8-11-59

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE: 8-31-59

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: Rowland Mortuary Svc. ADDRESS: 4104-06 Manchester

25. DATE RECEIVED BY LOCAL REG.: AUG 2 1959

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. L.P.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com
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.