RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-030462
STATE FILE NUMBER

FILED VS AUG 27 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7515

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS MO
Length of stay in 1b

c. CITY OR TOWN: ST.LOUIS, MO
Inside Limits: Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSP #1
Inside Limits: Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 2349 DIVISION
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: BABY Middle: GIRL Last: HARRIS

4. DATE OF DEATH: Month 7 Day 28 Year 59

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 7/28/59

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

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 country): ST.LOUIS,MO.

12. CITIZEN OF WHAT COUNTRY: U.S.A

13a. FATHER'S NAME: xxxxxxx

13b. MOTHER'S MAIDEN NAME: MARY HARRIS

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: ST. LOUIS CITY HOSP. #1. Address

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): atelectasis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Prematurity
DUE TO (c): 762.5

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 7/28/59, to 7/28/59 and last saw her/him alive on 7/28/59
Death occurred at 1:55 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title): R. James Vaccarella M.D.

22b. ADDRESS: 1515 LAFAYETTE AVE

22c. DATE SIGNED: 7-28-59

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE: 8-3-59

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

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

24. FUNERAL DIRECTOR ADDRESS: Rowland Aker 4104 Manchester

25. DATE RECD. BY LOCAL REG.: AUG 13 '59

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

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

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.