URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 21 1959

59-033701

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 8348

ENDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Mo.
Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Louis City Hosp. # 1
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): 9335 Morrison
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First BABY GIRL #1 Middle CRABTREE Last

4. DATE OF DEATH: Month Aug. Day 7 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8/7/59

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

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): St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: James Morgan Crabtree

13b. MOTHER'S MAIDEN NAME: Pearl Joann Neel

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: Pearl Crabtree Address: 935 Morrison

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): immaturity
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): atelectosis
DUE TO (c):
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 8/7/59 10:21a, to 8/7/59 and last saw her/him alive on 8/7/59.
Death occurred at 10:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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

22b. ADDRESS: 1515 Lafayette Ave.

22c. DATE SIGNED: 8/13/59

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE: 9-30-59

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.: SEP 10 '59

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

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

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 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 comp 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.