

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-034686**

**FILED VS SEP 21 1959**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2404

WENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u> Length of stay in lb <u>6 Days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's <del>Louisville</del> Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>6354 Waterman</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mary</u> Middle <u>Margaret</u> Last <u>Luckey</u>			<b>4. DATE OF DEATH</b> Month <u>Sept.</u> Day <u>6th</u> Year <u>1959</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9/1/59</u>	<b>9. AGE (last birthday)</b> <u>4/59</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u></u> Min. <u></u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Richmond Heights, Mo.</u>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>		<b>13a. FATHER'S NAME</b> <u>Horace L. Luckey</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Margaret Jeep</u>			
<b>14. NAME OF HUSBAND OR WIFE</b> <u>None</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>			
<b>17. INFORMANT</b> <u>Horace L. Luckey</u>		<b>Address</b> <u>Above</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>prematurity</u> DUE TO (c) <u>773.5</u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 hrs</u>		
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour <u></u> a.m. <u></u> p.m. <u></u>		<b>Month, Day, Year</b>					
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. I attended the deceased from</b> <u>9/1/59</u> to <u>9/6/59</u> and last saw her alive on <u>9/6/59</u> Death occurred at <u>10 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>C. K. Hammett M.D.</u>			<b>22b. ADDRESS</b> <u>3521 Central Clayton</u>		<b>22c. DATE SIGNED</b> <u>9/6/59</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>9-8-59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Peter's Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Louis Co. Mo.</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>JAY B. SMITH, Maplewood, Mo.</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-8-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>John B. Murphy M.D.</u>			

DOCUMENT

MEDICAL CERTIFICATION

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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