

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 23 1959

59-037512

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9293**

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i>		Length of stay in 1b		c. CITY OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>CHILDREN'S HOSPITAL</i>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>5012 DEVONSHIRE</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>DANA</i> Middle <i>LYDIA</i> Last <i>CRAIG</i>			4. DATE OF DEATH Month <i>OCT</i> Day <i>8</i> Year <i>1959</i>				
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>6/12/1939</i>	9. AGE (last birthday) <i>3</i> Months <i>26</i> Days	IF UNDER 1 YEAR Hours	IF UNDER 24 HR Min.
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) <i>ST. LOUIS, Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13a. FATHER'S NAME <i>MARLIN CRAIG</i>			13b. MOTHER'S MAIDEN NAME <i>SHARON BREMERKAMP</i>			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) <i>NO</i>		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address <i>MARLIN CRAIG 5012 DEVONSHIRE</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fractured skull with a subdural hemorrhage and a large laceration beneath the scalp which covered the entire cranium</i> DUE TO (b) <i>hemorrhage beneath the scalp which covered the entire cranium</i> DUE TO (c) <i>suffered in collision</i>						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) <i>left eye operated by Sharon Craig, in 1958</i>						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	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (State nature of injury in PART I or PART II of item 18.) <i>left eye operated by Sharon Craig, in 1958</i>					
20c. TIME OF INJURY <i>5:45</i> p.m.	Hour	Month, Day, Year <i>10 8 1959</i>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>on 2nd Street</i>				
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <i>St Louis Mo</i>	COUNTY	STATE				
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at _____ <i>740 P</i> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Joseph M Quinn</i>			22b. ADDRESS <i>1300 Clark Ave.</i>		22c. DATE SIGNED <i>10/10/59</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>10/10/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>SUNSET BURIAL PARK</i>		23d. LOCATION (City, town, or county) <i>AFFTON, Mo.</i>			
24. FUNERAL DIRECTOR <i>J L ZIEGENHEIN & SONS 7027 GRAVOIS</i>			25. DATE RECD. BY LOCAL REG. <i>OCT 10 1959</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>		

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

Lodd Benz

Licensed Embalmer No. 4863

P. O. Address St Louis, Mo

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.