

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

**59-037513**

**FILED VS NOV 6 1959**

**2 9891**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

RENDERED

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 <b>ST. LOUIS, MO.</b>		Length of stay in 1b		c. CITY OR TOWN <b>ST. LOUIS, MO.</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. # 1</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1015 A CALIFORNIA</b>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					

3. NAME OF DECEASED (Type or print) First Middle Last <b>BABY BOY CRAWFORD</b>			4. DATE OF DEATH Month Day Year <b>OCTOBER 14, 1959</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/2/59</b>	9. AGE (last birthday) IF UNDER 1 YEAR Months <b>10</b> ys IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>none</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
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13a. FATHER'S NAME <b>LAWRENCE</b>	13b. MOTHER'S MAIDEN NAME <b>MARIE TILLMAN</b>	14. NAME OF HUSBAND OR WIFE <b>_____</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT Address <b>ST. LOUIS CITY HOSPITAL #1.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningo myelocoele</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) _____ DUE TO (c) _____		
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>751x</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <b>OCT. 2, 59</b> to <b>OCT. 14, 59</b> and last saw her alive on <b>OCT. 14, 59</b>	
Death occurred at <b>2:20 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) <b>R. James Vaccaro M.D.</b>	22b. ADDRESS <b>1515 LAFAYETTE</b>	22c. DATE SIGNED <b>10/14/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>10-31-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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24. FUNERAL DIRECTOR <b>Rowland Mortuary Svc.</b>	ADDRESS <b>4104-06 Manchester</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 28 1959</b>	26. REGISTRAR'S SIGNATURE <b>Road Smith, M.D.</b>
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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.