

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037999

FILED VS NOV 3 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **3 9668** STATE FILE NUMBER

| | | | | | | | | |
|---|--|---|--|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO 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 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 2343 Madison Ave. 6 | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Rice | | | | 4. DATE OF DEATH Month Day Year Oct. 12 1959 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 10-12-1959 | | |
| 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) | | 10b. KIND OF BUSINESS OR INDUSTRY St. Louis MO | | |
| 11. BIRTHPLACE (City and state or country) St. Louis MO | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | | | |
| 13a. FATHER'S NAME Dug Wilburn Rice | | | 13b. MOTHER'S MAIDEN NAME Ruby Yvonne Vogt | | | 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 Dug or Rice 234 Madison Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature Birth, Neonatal death 1 hr. 10 min. DUE TO (b) Prenaturity from rupture of membrane DUE TO (c) Diabetes Mellitus of mother Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | 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) Edema Neonatorum. 769.6 | | | | | | 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 type="checkbox"/> NO <input checked="" 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.) | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | 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 | | |
| 21. I attended the deceased from 10-12-59 to 10-12-59 and last saw ^{her} him alive on 10-12-59 Death occurred at 6:05 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Norman G. Jones, M.D. | | | | 22b. ADDRESS 8321 N. Broadway (15) | | 22c. DATE SIGNED 10-12-59 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 10-31-59 | | 23c. NAME OF CEMETERY OR CREMATORY Anatomical Board | | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. | | |
| 24. FUNERAL DIRECTOR Rowland Aker 4104 Manchester | | | | 25. DATE RECD. BY LOCAL REG. OCT 22 1959 | | 26. REGISTRAR'S SIGNATURE Lead Smith, M.D. msb | | |

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.