

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008398

FILED VS MAR 11 1960

2 2472

STATE FILE NUMBER

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

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 ST. LOUIS, MO		c. CITY OR TOWN ST. LOUIS, MO	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS 1333 ST. ANGE	

3. NAME OF DECEASED (Type or print) First Middle Last BABY BOY DAMON INGE			4. DATE OF DEATH Month Day Year FEB. 18, 1960		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/17/60	9. AGE (last birthday) 23	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO	12. CITIZEN OF WHAT COUNTRY U.S.A	

13a. FATHER'S NAME CHARLES EDWARD INGE	13b. MOTHER'S MAIDEN NAME GERALDINE REED	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (or unknown)) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO. NONE
17. INFORMANT ST. LOUIS CITY HOSP. #1.		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) <i>atelectasis of lungs</i> DUE TO (b) <i>aspirated foreign material</i> DUE TO (c) <i>762.0</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)		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.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		

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 2/17/60 8:45 A to 2/18/60 and last saw her alive on 2/18/60 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <i>James Vaccarella, M.D.</i>	(Deceased or title)	22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 2/18/60
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE MAR 31 1960	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR Rowland Mortuary Svc. 4104-06 Manchester	ADDRESS	25. DATE RECD. BY LOCAL REG. MAR 3 1960	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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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  
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.