URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS MAR 7 1960

[redacted]

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2005 STATE FILE NUMBER 60-008705

ENDED

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri 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 ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1 — Inside Limits Yes ☐ No ☐	d. STREET ADDRESS (If outside, give location) 2528 Howard — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First: Valerie	Middle: Rhenae	Last: OWENS	4. DATE OF DEATH	Month: FEB. Day: 17, Year: 1960
5. SEX: Female	6. COLOR OR RACE: Colored	7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐	8. DATE OF BIRTH: 1-31-60	9. AGE (last birthday)	IF UNDER 1 YEAR: Months / Days: 16 — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baby	10b. KIND OF BUSINESS OR INDUSTRY: Baby	11. BIRTHPLACE (City and state or country): Missouri	12. CITIZEN OF WHAT COUNTRY: U.S.A.		
13a. FATHER'S NAME: Shepherd Owens	13b. MOTHER'S MAIDEN NAME: Pearlie Mae Battle	14. NAME OF HUSBAND OR WIFE: Baby			
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.: Baby	17. INFORMANT: Shepherd Owens	Address: 2528 Howard		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Meningitis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) 340.3

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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 1/31/60, to 2/17/60 and last saw her/him alive on 2/17/60

Death occurred at 10:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) R. James Vaccarella M.D. — 22b. ADDRESS 1515 LAFAYETTE AVE — 22c. DATE SIGNED 2/18/60

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal — 23b. DATE 2-22-60 — 23c. NAME OF CEMETERY OR CREMATORY Greenwood — 23d. LOCATION (City, town, or county) St. Louis County (State) Missouri

24. FUNERAL DIRECTOR Ellis Funeral Home — ADDRESS 2820 Stoddard — 25. DATE RECD. BY LOCAL REG. FEB 21 1960 — 26. REGISTRAR'S SIGNATURE Hoard Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

MDC

DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.