RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED WS MAR 3 1960

60-009246
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 570

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Richmond Heights — Length of stay in 1b: 31 hrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Mary's Hospital — Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: St. Louis
c. CITY OR TOWN: Overland — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 4523 Edmundson Dr. — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Robert Middle: Michael Last: Feldewerth
4. DATE OF DEATH: Month: February Day: 19, Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2-17-1960
9. AGE (last birthday): 31 hrs. — 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): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): St. Louis County, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Robert J. Feldewerth
13b. MOTHER'S MAIDEN NAME: Mary Ann Dickman
14. NAME OF HUSBAND OR WIFE: Single
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Robert J. Feldewerth Address: 4523 Edmundson Dr

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hyaline Membrane Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Prematurity
DUE TO (c):
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 birth to death and last saw her/him alive on 2-19-60
Death occurred at 2-19-60 10:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Ira C. Sall M.D. (Degree or title)
22b. ADDRESS: 201 S Central
22c. DATE SIGNED: 2/20/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-20-1960
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Missouri

24. FUNERAL DIRECTOR: Arthur J. Donnelly ADDRESS: 3840 Lindell Blvd.
25. DATE RECD. BY LOCAL REG.: 2-20-60
26. REGISTRAR'S SIGNATURE: John C. Murphy Jr. M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was not embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address 3840 Lindell

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