

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012639

4 FILED VS. MAR 25 1960

2 3088

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS - MO</i>		c. CITY OR TOWN <i>ST. LOUIS</i>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>D. O. A. CITY HOSP. TAL. M.</i>		d. STREET ADDRESS (If outside, give location) <i>3416 - BELL</i>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>BABY - (FOETUS) GRAY</i>			4. DATE OF DEATH Month <i>2</i> Day <i>15</i> Year <i>60</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>COL</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>2-15-60</i>
9. AGE (last birthday)		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	
IF UNDER 24 HR Hours _____ Min _____		5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <i>ST. LOUIS - MO</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A</i>	
13a. FATHER'S NAME <i>UNK</i>		13b. MOTHER'S MAIDEN NAME <i>ELLA - GRAY</i>	
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 <i>ELLA - GRAY - 3416 - BELL</i>		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>EXPOSURE - AFFECTING - THE - LUNGS</i> <i>FOLLOWING - PREMATURE - BIRTH - (6 MO. GESTATION)</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>IN - HOME - FEB - 13 - 1960</i> DUE TO (c) <i>7625</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 _____ 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 <i>515 P.</i> and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John J. [Signature]</i>		22b. ADDRESS <i>1300 Clark</i>	22c. DATE SIGNED <i>2-23-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>3-31-60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>
24. FUNERAL DIRECTOR <i>Rowland Mortuary Svc.</i>	ADDRESS <i>4104-06 Manchester</i>	25. DATE RECD. BY LOCAL REG. <i>MAR 17 1960</i>	26. REGISTRAR'S SIGNATURE <i>Kear Smith, M.D.</i>

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.