

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-020643

FILED VS JUN 9 1960 318

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 5587

STATE FILE NUMBER

INDEXED

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		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 Lutheran Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4312 Jessica		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Baby Boy			4. DATE OF DEATH Month Day Year 5 - 30 - 60		
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 5-30-60		9. AGE (last birthday)		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Missouri.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Bob Bernard Barhorst		13b. MOTHER'S MAIDEN NAME Audrey Ruth Rose	
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 Audrey Barhorst		Address 4312 Jessica			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anencephaly</u>					INTERVAL BETWEEN ONSET AND DEATH 55 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>750x</u>					
DUE TO (c)					
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 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 <u>May 30, 1960</u> to <u>May 30, 1960</u> and last saw him alive on <u>May 30, 1960</u> Death occurred at <u>3:10 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Francis G. Weind M.D.</u>			22b. ADDRESS <u>5203 @ Pappan</u>		22c. DATE SIGNED <u>5-30-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>5-31-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>	
23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u>		23e. (State)			
24. FUNERAL DIRECTOR <u>Kriegshauser 4228 S. Kingshighway</u>			25. DATE RECD. BY LOCAL REG. <u>MAY 31 1960</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>

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 _____

No Embalming
Signature of Student Embalmer

Signed *R. V. Storvick* _____

Licensed Embalmer No. *4007*

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.