

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 2 1960

7843-60-032095
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

NDED

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|---|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. LOUIS</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u> | | Length of stay in 1b <u>2 days</u> | c. CITY OR TOWN <u>ST. LOUIS</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOHN'S</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>6722 RAYMOND</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY (GIRL) DENAROYE</u> | | | 4. DATE OF DEATH Month Day Year <u>8 8 60</u> | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-6-60</u> | 9. AGE (last birthday) <u>2</u> | IF UNDER 1 YEAR Months Days Hours Min. <u>2</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | 11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO</u> | 12. CITIZEN OF WHAT COUNTRY <u>AMERICA</u> | |
| 13a. FATHER'S NAME <u>ELMER DELAROYE</u> | | 13b. MOTHER'S MAIDEN NAME <u>EMILY CARPENTER</u> | | 14. NAME OF HUSBAND OR WIFE <u>---</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>---</u> | 17. INFORMANT Address <u>6722 RAYMOND 33</u> | | |

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

IMMEDIATE CAUSE (a) MASSIVE BILATERAL ATLECTASIS

DOE TO (b) PREMATURITY

DOE TO (c) 762.5

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

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 <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.) <u>---</u> | |
| 20c. TIME OF INJURY Hour a.m. p.m. <u>---</u> | Month, Day, Year | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u> | 20f. CITY, TOWN, OR LOCATION <u>---</u> | COUNTY STATE |
| 21. I attended the deceased from <u>8-6-60</u> to <u>8-8-60</u> and last saw ^{her} alive on <u>8-8-60</u> Death occurred at <u>10:05 PM.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |

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|---|--------------------------------|---------------------------------------|-----------------------------------|
| 22a. SIGNATURE <u>Daniel J. Martin</u> | (Degree or title) <u>MO</u> | 22b. ADDRESS <u>307 So. Euclid</u> | 22c. DATE SIGNED <u>8-9-60</u> |
|---|--------------------------------|---------------------------------------|-----------------------------------|

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|---|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>8-9-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | 23d. LOCATION (City, town, or county) <u>St. Louis mo</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Ottmann F Home Overland mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>AUG 9 1960</u> | 26. REGISTRAR'S SIGNATURE <u>Earl 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *No Embalming*
James Haester

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.