IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 17 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7922 -60-032515 STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Homer G. Phillips
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4858 Easton
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Stephen Middle: McKay Last: Lee
4. DATE OF DEATH: Month: 8 Day: 6 Year: 60
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8-6-60
9. AGE (last birthday)
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HR: Hours: 2 Min.: 27
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): Saint Louis, Missouri
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME
13b. MOTHER'S MAIDEN NAME: Barbara Ann Lee
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: Mrs. Mary D. Jack, R.R.1, Address: 2601 N. Whittier

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): Atelectasis of lungs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Severe prematurity
DUE TO (c): 762-5
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 8-6-60 to 8-6-60 and last saw ~~XX~~ him alive on 8-6-60
Death occurred at 3:55 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Earl Smith, M. D.
22b. ADDRESS: 2601 N. Whittier
22c. DATE SIGNED: 8-8-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: AUG 31 1960
23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.
24. FUNERAL DIRECTOR: Rowland Mortuary Svc. ADDRESS: 4104-06 Manchester
25. DATE RECD. BY LOCAL REG.: AUG 11 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. MC

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 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.